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H.R. 4935 AND DVA'S MEDICAL CARE COST RECOVERY PROGRAM

HEARING

BEFORE THE

SUBCOMMITTEE ON
HOSPITALS AND HEALTH CARE

OF THE

COMMITTEE ON VETERANS' AFFAIRS
HOUSE OF REPRESENTATIVES

ONE HUNDRED FIRST CONGRESS

SECOND SESSION

JUNE 20, 1990

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H.R. 4935 AND DVA'S MEDICAL CARE COST RECOVERY PROGRAM

WEDNESDAY, JUNE 20, 1990

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The subcommittee met, pursuant to notice, at 9:02 a.m., in room 334, Cannon House Office Building, Hon. J. Roy Rowland (acting chairman of the subcommittee) presiding.

Present: Rowland of Georgia, Montgomery, Stenholm, Kennedy, Patterson, Jontz, McEwen, and Bilirakis.

OPENING STATEMENT OF HON. J. ROY ROWLAND, ACTING CHAIRMAN

Mr. ROWLAND OF GEORGIA. Good morning. The subcommittee will come to order.

We are meeting this morning to receive testimony regarding the Department of Veterans' Affair's medical care cost recovery program, including H.R. 4935, the Department's proposed legislation on cost recovery.

This committee has long been interested in recouping the cost of medical care provided to veterans with non-service-connected disabilities. In Public Law 99–272, enacted in 1986, authority for the VA to collect such third party reimbursements from private insurers was established. H.R. 5114, which passed the House on September 22, 1988, required the then Administrator to establish a 2-year pilot program for fiscal years 1989 and 1990 for an improved, automated management system for billing and collection of such fees.

It would also have provided that some of the funds received under the pilot program would be retained by the medical center. Some collections would be retained by the Chief Medical Director for pay and personnel benefits to enhance the recruitment and retention of staff and to supplement medical equipment accounts.

H.R. 901, as amended, which passed the House on June 22, 1989, would have provided for an improved system for collection of fees and retention of some of the fees recovered. However, we have not reached agreement with the Senate on either of these provisions.

Our hearing this morning will focus on this subject with particular emphasis on two GAO reports, the Department's proposed H.R. 4935, and experience in the field. The success of the Department in collecting from third party health insurers has been spotty at best. In part, this is certainly due to the fact that there has been no

funding provided to pursue collections, there is no incentive for the medical centers to pursue collections, and there is resistance from insurers to cooperate with the Department. Our hearing today is designed to understand the problems and opportunities for collections.

Our witnesses include the General Accounting Office, the Department of Veterans Affairs, a panel of field personnel who actually implement the collection process, a private sector consultant who has worked in the Department setting, and veterans service organizations.

I have a special interest in this topic because of a directly related idea that the Department of Veterans Affairs medical system is an efficient, effective and economical way to provide health care. Across our Nation there are about 70 million citizens who have either no insurance or who are inadequately insured.

One result of improving our ability to make collections will be an ability to demonstrate more clearly the efficiencies that have been achieved by the Department. I believe that the Department will be able to demonstrate that it can deliver care to a low-income population, along with the service-connected population, in a way that might transform American medicine.

In a related line of thought I want to talk about a serious chain of events that is happening right now in the VA. The shortage of resources has resulted in beds closed and these closures are a direct result of the shortage of funds for supplies and equipment and, indirectly, as a result of the shortage of funds to staff the beds. The closures yield low occupancies for the VA in some cases because fewer veterans, in fact, get care. The low utilization and decreasing workload, especially for so-called Category B and C veterans, provide decreasing support for funds, and so the cycle accelerates.

Recovering third party reimbursements and increasing other revenues can make productive capacity that is currently unused. The greater capacity can treat more patients, justify more funds, and end the cycle of self-immolation.

I will now call our first panel of witnesses this morning. Mr. Edward Densmore, who is Director of Planning and Reporting, Human Resources Division, General Accounting Office. And, without objection, Congressman Staggers wants to submit a statement of support for retaining collections at the local hospitals.

[The statement of Hon. Harley Staggers appears at p. 47.]

Mr. ROWLAND OF GEORGIA. Mr. Densmore, if you will introduce those who are accompanying you this morning.

STATEMENT OF EDWARD A. DENSMORE, DIRECTOR, PLANNING AND REPORTING, HUMAN RESOURCES DIVISION, GENERAL ACCOUNTING OFFICE; ACCOMPANIED BY PAUL REYNOLDS, ASSISTANT DIRECTOR, HUMAN RESOURCES DIVISION; WALTER GEMBACZ, ASSIGNMENT MANAGER, HUMAN RESOURCES DIVISION

Mr. DENSMORE. Yes, sir, Mr. Chairman. On my right is Mr. Paul Reynolds, who is an Assistant Director in the Human Resources Division and is responsible for the health work that we do at the Department of Veterans Affairs. On my left is Mr. Walter Gembacz,

who is a senior evaluator in the Human Resources Division, responsible for the two reports that we're going to be talking about today.

Mr. ROWLAND OF GEORGIA. Thank you very much, Mr. Densmore. You may proceed in your own manner.

Mr. DENSMORE. We have a statement that we will submit for the record, Mr. Chairman, and I will briefly summarize that statement for you now.

We are pleased to be here today to discuss the VA health care cost recoveries. As part of the Veterans' Health Care Amendments of 1986, the Congress included two provisions to help reduce the Federal budget deficit. First, the Congress authorized VA to collect from insurers, and second, the Congress required VA to collect copayments from veterans.

As you know, we recently issued two reports discussing VA's efforts to implement the '86 amendments. These reports summarized the results of our work at six VA medical centers and our analysis of responses to a questionnaire that all 159 medical centers completed.

Our work showed that VA's collections exceeded its collection costs substantially. VA's 159 medical centers collected about $100 million in fiscal year 1988 from health insurers at a cost of about $8 million, which is a 12 to 1 ratio. However, the centers could have collected substantially more—we estimate about $223 million additional in 1988. VA's collections of copayments also exceeded costs in that year, with collections of about $10 million at a cost of about $7 million. As with insurance recoveries, centers' collections of copayments should have been significantly higher than they were.

The cost recovery performance of the 159 centers varied widely. Ineffective procedures at most centers and a reluctance to use the resources needed to maximize recoveries contributed to missed collection opportunities. The centers struggled, in large part, because VA's top management delegated responsibility for recoveries to them but failed to provide the direction and the tools needed to get the job done right.

Given the substantial benefit to the Government, we concluded that VA's top management should take a more active role in helping medical centers maximize collections from health insurers and veterans. We made several recommendations to the Secretary of Veterans Affairs to do this.

The Secretary responded quickly to address our recommendations by establishing a top-level management team to develop a comprehensive plan for improving VA's recovery procedures, and developing a legislative proposal to finance the insurance recovery effort. We have met with VA's team and are encouraged with the progress it has made in developing a comprehensive improvement plan. I should note that the plan included a project to identify veterans who were provided care since January, 1989, but whose insurance companies were not billed. The VA believes that, if it is successful, this project alone could result in recoveries of more than $200 million.

VA's proposed legislation would establish a special fund to pay for the necessary personnel and administrative costs of the insur-

ance recovery effort. All collections would be deposited into this fund. The VA will use the fund to cover its recovery costs up to a prescribed ceiling, currently proposed as $25 million, and return the remaining balance to the U.S. Treasury.

We believe the Secretary's proposal offers a viable approach to providing centers with the resources needed to maximize their insurance recoveries. It would also provide VA the flexibility to use a portion of its collections either to contract for services or utilize its own personnel. In our view, VA should actively pursue whichever alternative results in the lowest recovery cost and thereby allows the highest return to the Treasury.

Mr. Chairman, as I indicated at the beginning, VA has the opportunity to significantly increase its health care cost recoveries. Although VA got off to a slow start, it now appears to be on the right road to realize more fully its cost recovery potential. This progress would not have been possible, within such a short time, were it not for the leadership exhibited by VA's top management concerning this important issue.

This concludes our statement. We would be happy to respond to any questions that you or the other members may have.

[The prepared statement of Edward A. Densmore appears at p. 49.]

Mr. ROWLAND OF GEORGIA. Thank you, Mr. Densmore.

Before we go to questions, I want to recognize Mr. McEwen for an opening statement, if he has an opening statement.

Mr. MCEWEN. Thank you, Mr. Chairman. I do have an opening statement, as well as Mr. Hammerschmidt, the ranking member of the subcommittee, as well as Mr. Smith of New Jersey. With your permission, I will ask that all three be inserted in the record at this time.

Mr. ROWLAND OF GEORGIA. Without objection.

Mr. MCEWEN. Thank you.

[The statements of Hon. Bob McEwen, John Paul Hammerschmidt, and Hon. Chris Smith appear at pp. 42, 41 and 45.]

Mr. ROWLAND OF GEORGIA. Mr. Densmore, the VFW has raised in testimony the idea that health insurance premiums would rise if non-service-connected care were to be collected from service-connected veterans. The GAO performed some studies of health insurance costs some years ago. What is your view of this fear that the VFW has?

Mr. DENSMORE. Let me ask Mr. Reynolds to address that, Mr. Chairman.

Mr. REYNOLDS. We believe that the premiums would not rise significantly. In fact, they would probably rise very little. The insurance policies were written using information on the numbers of people who would need health care, and whether the health care was provided by the VA or in a private sector hospital was not a big concern in pricing.

Mr. ROWLAND OF GEORGIA. Is the VA plan to bill all insured veterans who receive VA care since January of 1989 a doable task?

Mr. DENSMORE. Yes, sir, I believe that they can.

Mr. ROWLAND OF GEORGIA. I yield to the Chairman.

Mr. MONTGOMERY. Mr. Chairman, I want to thank you, Dr. Rowland, and Mr. McEwen, for your help in chairing this meeting this

morning. I'm going to have to leave in a few minutes. I want to thank the General Accounting Office for the report you made and also some of the suggestions you've made that would help us in this third party reimbursement. We still depend on the General Accounting Office and thank you very much for some of the leads you've given us. I think we will try to follow up on it. As I understand it, the DVA is also making some moves to take your suggestions.

Thank you.

Mr. ROWLAND OF GEORGIA. Mr. Chairman, I apologize. I thought you had already left when I failed to recognize——

Mr. MONTGOMERY. I always try to be very inconspicuous.

Mr. ROWLAND OF GEORGIA. Mr. Chairman, you are never inconspicuous. I apologize for not having recognized you. I thought you had already left.

Mr. Stenholm.

Mr. STENHOLM. No questions.

Mr. ROWLAND OF GEORGIA. Mr. McEwen.

Mr. MCEWEN. Thank you, Mr. Chairman.

What is the reason that we shouldn't do this? What's the greatest disincentive to VA having pursued this with a vengence up until now?

Mr. DENSMORE. I don't know that there's any disincentive not to pursue. I think the disincentive that the VA has had in the past is that it didn't have the funds to aggressively pursue this. The funds would have had to come from their medical care budget, and it was a question of using those funds to provide care or to pursue recovery. But I think that with the proposal now to set up a special fund that will allow them to pursue the recovery without impacting on their medical care budget, there are no real disincentives to the Department of Veterans Affairs.

And from the veterans' point of view, it will not affect the care or the cost to the veteran because we'll only be talking about recovery from insurance companies where there are insurance policies in effect to cover the care provided.

Mr. MCEWEN. There is some concern in rural America that the VA hospital system is becoming increasingly overwhelmed with World War II veterans, et cetera. Right next door to them are rural hospitals that are closing their doors because of an insufficient number of patients.

Do you have any thoughts as to how we can get service to the veterans and keep those hospitals functioning, to provide better service? Certainly it would take care of the third party payment difficulties that are the specialty of private hospitals.

Mr. DENSMORE. I don't have a real good answer to that question. We are doing, in the Human Resources Division at GAO, two or three jobs right now that deal with rural hospital closures. In fact, we issued a report yesterday that dealt with some of the factors behind that. Basically, it's small size and low occupancy rates. In a lot of cases, those hospitals are closing because there are a lot of other hospitals in the vicinity that can provide the care, including VA hospitals.

Mr. MCEWEN. Could you get that report to me?

Mr. DENSMORE. Yes, sir.

Mr. MCEWEN. Thank you, Mr. Chairman.

Mr. ROWLAND OF GEORGIA. Thank you, Mr. McEwen.

Let me ask you this, Mr. Densmore. Could collections be made more efficiently if the DVA contracted out the billings and collection of third party reimbursements, or would that be better done in-house?

Mr. DENSMORE. That very well could vary, depending upon the individual hospitals. I don't think that we have any position with regard to one way or the other that would be better across the board. In some cases it may be cheaper to contract out and in other cases it might be cheaper to do it in-house. It might even depend on the particular function that we're talking about.

For instance, collections; it may be economical to contract to some outside collection agency to follow up on collections. So it's the type of thing that I think would have to be looked at on a case-by-case basis, both from the individual hospital and from the particular functions that we're talking about.

Mr. ROWLAND OF GEORGIA. Do you think perhaps that should be left up to hospital directors in each hospital as to whether or not it would be appropriate for them to contract out, or do you think we should have an overall policy?

Mr. DENSMORE. There probably should be some overall policy with some direction and guidance from the VA headquarters, but there should probably be some flexibility or something left to the judgment of the individual hospitals.

Mr. ROWLAND OF GEORGIA. Are copayments more costly to collect, do you think, than third party collections, and if so, why?

Mr. REYNOLDS. The information that was provided to us during our review showed the costs to be roughly the same for the 1988 year we were looking at. However, copayments offer the opportunity for tremendous efficiencies. For instance, the veterans are actually on site and the bill could be provided in person, which would save mailing costs and other associated costs. Also, the collections might be made on site which would also greatly reduce administrative costs.

We have looked at some literature and visited some private hospitals and they generate a rather substantial amount of their first party collections right on site at the time the care is provided. So the opportunity for efficiencies in reducing the costs of copayments is much greater than insurance.

Mr. ROWLAND OF GEORGIA. I indicated in my opening statement a concern that I have, that we have lost beds in our VA hospitals, and subsequent to that, we lost personnel. Veterans are not using the hospitals, it is said, and we seem to have set up a cycle. We reduce the beds, less personnel, reduce more beds, less personnel. It seems to me that we're getting into a very precarious situation with reference to the efficiency and autonomy of our VA health care system.

It seems to me that if we could inject some new money or some additional money into the system, we might be able to reverse this trend. Is my thinking on this with good foundation or not? Would you care to comment on what I've just said?

Mr. REYNOLDS. I think that over the last 2 years the system has incurred some tremendous budget pressures. We've seen that as

we've gone around doing our work. This improvement in VA's recovery efforts will generate, based on the estimates of both VA and our own people, some tremendous revenue, anywhere from $200–400 million a year. So it will provide some opportunity. How best that money should be used is really a policy decision and one best left to others than ourselves.

Mr. ROWLAND OF GEORGIA. We have seen reports in the newspapers recently that the quality of care in the VA is not as good as it has been in the private sector. While I don't subscribe to that, that also is some concern. We have had some horizontal cuts over the past few years because of budgetary constraints that we've had.

It always seems to me that if you can utilize a system, whatever it happens to be, it works much better. It seems to me that we've been on a downhill course, and if we don't reverse this course, I feel we might lose the autonomy of the entire VA health care system. Certainly with the decreasing number of veterans we might have in the outyears, it is a great concern to me.

Would you care to comment on that?

Mr. REYNOLDS. I think in our past work we have seen reason to agree with you, that the more something is utilized, the better the care will become. Two years ago we looked at cardiac surgery, for example, and found they were having utilization problems and the standards that were set were difficult standards for VA to meet with the number of units they had operating. One way to get at that is to reduce the number of units; the other way, obviously, is to increase the utilization and attract veterans to the system so that the utilization will go up.

I think that is one of the focuses of the Commission which is at this time having its first meeting. I think that's an issue they will deal with, and it's a tough issue. But we tend to agree that increasing the utilization will definitely impact the quality of care.

Mr. ROWLAND OF GEORGIA. Mr. McEwen.

Mr. MCEWEN. Nothing more, Mr. Chairman.

Mr. ROWLAND OF GEORGIA. Mr. Stenholm.

Mr. STENHOLM. Just hurriedly reading through your testimony, and also Mr. McCann's, perception is that the problem on the collection of these copayments has been twofold. One, it has been a little too much trouble—at least in the eyes of the people that are responsible for collecting them—and that even if they took the trouble, there was no mechanism in place that would reward them for doing the job. They may collect $200–$400 million more but that money would not have gone to benefit the individual hospital or individual people responsible for making that decision and, therefore, it was very easy to make the determination that this is more trouble than it's worth.

Is that a correct perception?

Mr. DENSMORE. Yes, sir, it is.

Mr. STENHOLM. The VA is already implementing many of these recommendations because they agree that if an individual hospital does a good job in collecting—by a good job, you don't spend more collecting than you take in—that the benefits of that will accrue to the health care needs of the veterans in that particular hospital or in the VA in general.

Mr. DENSMORE. Basically, that fund will provide the expenses to pursue the collections, and the excess funds will be returned to the United States Treasury. So what is happening is that the incentive is that the individual hospitals will not have to use health care funds to pursue the billing and collections.

Mr. STENHOLM. Would there be any benefit in going one step further to allowing some of the rewards to accrue to the local entity rather than having all of the so-called profits accrue back to the Treasury as a whole?

Mr. DENSMORE. That has been discussed as a possible option.

Mr. STENHOLM. What would you recommend?

Mr. DENSMORE. What would you recommend?

Mr. STENHOLM. Yes.

Mr. DENSMORE. Within certain guidelines or some criteria, I don't think we would be opposed to some of those moneys going to the individual hospitals to provide care. I think there would have to be criteria and there would have to be some restrictions so that those funds are not misused. But it would provide additional incentives for the hospitals to pursue collections.

Mr. STENHOLM. You said proper restrictions would have to be put in. Can you think of any other downside to a process that would encourage the administrative office of the VA hospital to seek those collections?

Mr. DENSMORE. A downside would be, of course, that there would be less revenues going into the Treasury. It would circumvent the budget process or the appropriations process to some extent, and there is a concern that possibly OMB might reduce the VA appropriation request by amounts that they anticipate the hospitals may recover. So those are the types of things that could happen.

Mr. STENHOLM. That could happen, but that strikes me as something we could devise rules and regulations to see that it would not happen.

Mr. DENSMORE. I think we're in agreement. The thing is that you have some restrictions and you have some criteria that have to be followed, just to preclude the types of things we're talking about.

Mr. STENHOLM. Thank you.

Mr. ROWLAND OF GEORGIA. The gentleman certainly raises a very valid point. I appreciate that.

Mr. McEwen.

Mr. MCEWEN. Thank you, Mr. Chairman. Just one quick question.

How would you suggest we go about providing the incentive to the hospital to make these collections? How do we get that money to them?

Mr. REYNOLDS. The money that you're talking about would be the money that would be over and above the costs of collection, how would that best go back to the hospitals?

Mr. MCEWEN. Yes.

Mr. REYNOLDS. I think through the type of criterion and controls we were talking about—The concern is that the money go to the places in the system that need it the most, and they may not be the places that have the largest collections. So you could face a situation where more money is going to a place that may not have the greatest need. I think that would be a concern, to make sure

this extra money was going to the highest priority needs in the system, or at a particular hospital.

Mr. ROWLAND OF GEORGIA. Mr. Stenholm.

Mr. STENHOLM. My question is, the uncertainty of the individual veteran as to whether or not, if they report they have insurance, they are, in fact, going to jeopardize their chance for health care. Quite often now we're finding that a lot of our insurance payments, particularly with those over 65, a lot of folks have been sold something that's not worth much when they get into the hospital. It's a frustration that I'm finding with the general population.

In your investigation, in either of your two studies, did you look further into that problem and make any recommendations as to whether or not the education process of the VA is sufficient or could be improved on?

Mr. GEMBACZ. Yes, we did look into the education process when VA began to do recoveries from health insurance and copayments. They did initially try to educate the veteran and there were pamphlets and brochures and everything provided, but then the education kind of went by the wayside. But VA's new group that is improving procedures and things are really focusing and emphasizing education again. So I think that will be taken care of with the new procedures and things that the VA plans to do.

Mr. STENHOLM. Thank you.

Mr. ROWLAND OF GEORGIA. Thank you. I want to thank you gentlemen for coming.

Mr. Jontz has come in. Do you have a question you wanted to ask this panel?

Mr. JONTZ. Just very briefly, if I might. I apologize if you've covered this in your statement. I haven't had a chance to review the report, so perhaps it is addressed in here.

Some of the veterans groups will be speaking to this committee about their concerns. I'm reviewing the testimony of the VFW and they express apprehension about what could happen to a low-income Category A veteran with a non-service-connected disability who has some modest level of health insurance through a personal policy or small group policy, and the implications or the impact this would have on their premiums and whether this would possibly result in increases in premiums to the point where insurance wouldn't be affordable to them and policies would be canceled, not only resulting in the loss of insurance to the veteran but also to his family. That sort of follows on the gentleman from Texas' question.

Do you have any response to that concern?

Mr. REYNOLDS. We did a report about 5 years ago looking into a number of issues before the legislation was passed. One of them was the premiums. That report concluded that there would not be very much of an impact on the premiums.

Since that time, in going around and doing this work, we have actually heard persuasive arguments that would bolster that, in that VA, to the insurance companies, may be a lower cost alternative than a private hospital. In other words, if a veteran goes to the VA for a condition, the insurance company may actually be billed a lower amount than they would be billed if they went to a private hospital. If that's the case, insurance costs would go down and maybe the premiums would also.

Mr. JONTZ. Do we have some experience to base that on?

Mr. REYNOLDS. We haven't done any work, but there are others who have looked into the rates. I believe the VA would be prepared to address that.

Mr. JONTZ. Okay. Thank you.

Mr. ROWLAND OF GEORGIA. Thank you.

Gentlemen, thank you very much. We appreciate your appearance.

I also want to recognize that Congressman Kennedy has come into the hearing room.

The next panel is Mr. S. Anthony McCann. Tony, thank you very much for being here this morning. If you would introduce those who are accompanying you.

STATEMENT OF S. ANTHONY MCCANN, ASSISTANT SECRETARY FOR FINANCE AND PLANNING, DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY RAY BLUNT, SPECIAL ASSISTANT TO THE ASSISTANT SECRETARY FOR FINANCE AND PLANNING; FRANK D. DERVILLE, DEPUTY ASSISTANT SECRETARY FOR FINANCIAL MANAGEMENT; DOUGLAS BRADSHAW, DEPUTY ASSISTANT GENERAL COUNSEL; AND DANIEL H. WINSHIP, M.D., ASSISTANT DEPUTY CHIEF MEDICAL DIRECTOR FOR OPERATIONS

Mr. MCCANN. Mr. Chairman, my name is Tony McCann. I am the Assistant Secretary for Finance and Planning at the Department of Veterans Affairs. I am pleased to be here today to testify on behalf of the administration on H.R. 4935 and on our medical care cost recovery program.

With me today are a number of people from the DVA. Mr. Ray Blunt, next to me, is Special Assistant to the Assistant Secretary, who is, with Dr. Winship's staff, spearheading our third party collection activities. At the far end of the table is Mr. Frank Derville, the Deputy Assistant Secretary for Financial Management in the Department. Immediately next to me is Doug Bradshaw, the Deputy Assistant General Counsel in charge of this area. And I think all of you know Dr. Daniel Winship, the Assistant Deputy Chief Medical Director for Operations.

Mr. ROWLAND OF GEORGIA. Than you very much. You may proceed in your own manner.

Mr. MCCANN. Mr. Chairman, I will summarize my statement, if you will.

In the fall, Mr. Chairman, in reviewing our performance on the medical care cost recovery program since 1986, we concluded that the Department had in no way achieved the recoveries originally envisioned by it, by OMB, or by the Congressional Budget Office, when they made the estimates of collections to be achieved in that bill. An analysis done for my office indicated that, under current law, we could recover approximately $400–$700 million per year, an increase of approximately $250 million annually. As a result of that review, the Secretary decided to make this a departmental level priority.

Since that decision, the Chief Medical Director and I have formed a joint development group comprised of 20 individuals

drawn from top medical centers, the General Counsel's Office, and Central Office staff. Their charge has been to develop an implementation plan to put the medical care cost recovery program on a sound footing across the country.

Fortunately, they have been able to benefit from two comprehensive studies that were completed earlier this year: the report of the Medical Care Cost Recovery Task Force, a group drawn primarily from the field, which was convened at Dr. Winship's initiative last year, and the GAO report in March about which you have just heard. We obviously also have consulted very carefully with a number of the field representatives who you will hear from immediately after we complete our testimony.

Both the task force and the GAO recommendations reinforce earlier analyses done by my office, that the recovery potential was significant but that the VA could improve its management of the program. Particularly, there had to be a better means of identifying veterans with insurance, producing timely bills when the veteran is discharged, and following up on that bill to collect the cost. These reports and the early analysis formed the basis for identifying 43 tasks that were developed by the joint development group in the implementation plan. That plan, shared earlier with the committee staff, represents our planned actions, objectives and schedule with milestones by which we plan to hold ourselves accountable for this activity.

The plan includes procedures for implementing the recovery fund should Congress authorize it; a national training seminar in September; a complete "how to" handbook to be distributed to all employees; local training in interviewing for the identification of insurance; major improvements in systems development; improved communication with the veterans to encourage their cooperation; establishing effective working relationships with insurers; the use of a national menu contract to allow flexible choice by field stations with respect to meeting their needs and implementing the program; and issuing timely and accurate billing rates.

We also, as was mentioned earlier, intend to launch a back-billing project to identify those veterans whose insurers have not been billed or who have not been identified. This effort will go back to January 1, 1989 to bill and collect several millions of dollars that may go otherwise uncollected.

From a management standpoint, we are asking every medical center to establish a medical care cost recovery unit and to name a coordinator responsible for implementing the program as planned. Each regional director, station director and functional manager in the field, as well as program managers in Central Office, will have medical care cost recovery performance in their personnel performance standards.

Mr. Chairman, these are the highlights of our program improvements. We believe that with the addition of 300 FTE requested in the President's budget, and the adding of the 500 FTE now working in the field, we can make major steps towards recovering an additional $250 million next year if the medical care cost recovery fund is enacted.

The fund itself is to be capitalized at $25 million and must be reimbursed from collections for the salaries and employees in the

medical care cost recovery program and for automation and contracting. This is an important incentive to cost recoveries that is now lacking. This approach will remove the dilemma from the medical center director of having to choose between medical care services and medical care cost recovery. Additional recoveries of $250 million next year will make this $25 million well worth investing.

In short, we can and will do a significantly better job in implementation. The Chief Medical Director and I are committed to reviewing this project every 6 weeks in order to ensure that the tasks are being fully implemented and accomplished.

Mr. Chairman, let me also be clear that, as the Chief Financial Officer, it is my job to spearhead the implementation of the program, it's planning, tracking, task development and ensuring things stay on track.

Ultimately, this is a VHS&RA program. It is the Chief Medical Director's responsibility for its day-to-day operation once it's established. My job is similar to my relationship with all other financial programs, which is to assure that they're being properly implemented and carried out in a manner which is consistent with fiscal and other rules of the Federal Government.

Mr. Chairman and members of the committee, as Chief Financial Officer of the Department of Veterans Affairs, I strongly recommend passage of H.R. 4935. It is extremely important if we are to recover those costs which we are mandated to collect under law. When the Veterans' Administration was being considered for elevation to the President's Cabinet, the decision was made to put the new Department on a far more solid and professional management footing than it had been previously. It is my reasoned judgment that this bill does just that and places the tools in the hands of dedicated employees like those before you and those who you will see after me to do the job effectively that we have asked them to do.

Mr. Chairman, that completes my statement. I would be pleased to try and answer any questions that I can.

[The prepared statement of S. Anthony McCann appears at p. 57.]

Mr. ROWLAND OF GEORGIA. Thank you, Mr. McCann.

Mr. Stenholm.

Mr. STENHOLM. I want to pursue the same question with you, Mr. McCann, that I did the previous witness, in light of the recommendations and some of the comments that you've made today.

First of all, as I understand it, you have made the decision to shift personnel, to shift 500 people within the service. Why did you make that determination and not look more closely at contracting out? Most of the figures I have seen show that we are undermanned in our VA system now.

Mr. MCCANN. Much of the problem that was identified by the task force and by the various studies dealt with the way in which veterans are admitted to our hospitals and the kinds of questions we asked them and the assurance that our system is, in fact, capable of telling us the services we have provided to the veteran. Those are very inherently VA activities. What we did to determine the number of 500 was we asked VHS&RA how many people are

involved in that process now, and the number we got back was about 500.

I might add that I don't think—I'm quite sure, in fact, that the VA strongly supports the concept of contracting and we are proposing to provide a flexible tool by which we can do it. But much of our problem is the way in which we address ourselves to the veteran when he presents himself to our hospitals, the interviewings on admission and so on. My sense of it is, although I would ask Dr. Winship to elaborate further, is that that's not the kind of thing we feel comfortable having a contractor do.

Dr. WINSHIP. I believe, Mr. Stenholm, that we will be comfortable with having certain segments of this contracted, and to that end we are proposing there be flexible contracts.

There is, however, a major component of the activity surrounding the patient which really must be carried out by clinical people. I believe that, as we look at the operation that we have, the way the whole billing operation goes, there are many people, other than those that just make out the bill, other than those that just take the patient in and those that make out the bill, that will ultimately be involved with some portion of what that bill is going to be for the veterans.

To that end, then, it seems to us that to have available to us, where appropriate, certain pieces that we can, at our discretion, contract for, that will enhance our activities, will be appropriate. But to contract the whole operation would not be appropriate for those reasons.

Mr. MCCANN. Mr. Stenholm, if I might add one other point, both in this active regard and in a broader contracting regard, one of the things that we are concerned about is a piece of legislation introduced by Mr. Conyers relating to contracting out. One of the things we think it might do is to require us, in circumstances such as this, to go through a lengthy A–76 type process in order to make these decisions. As I think all of you know, the VA contracts an immense amount of activities out and we are very concerned that some of its provisions might substantially limit our capacity to do that based on decisions made in the field by hospital administrators and directors and chiefs of staff at the hospital level. So that's another concern we have with respect to contracting out.

Mr. STENHOLM. I'm very sympathetic with you on that one. The individuals who continue to believe that contracting out in all instances is bad defy my understanding. I sympathize with you on that.

I have a couple of other questions. I'm curious as to the process in which you indicate possibly $400 million we could recover. I understand 500 personnel would cost something like $13 million. Why the decision not to include that $13 million in the $400 million for budgetary purposes instead of shifting 500 people in an already manpower short area? What was the logic in that?

Mr. MCCANN. Let me split that question, too, if I might. The question of how we came upon the $400–700 million was based on an analysis done in my office by some of our statistical people. Let me ask Mr. Blunt to respond to that quickly.

Mr. BLUNT. Sir, we've looked at essentially the population which we serve, the people who actually use the system. We then did an

analysis of how many of those have insurance which would be billable. We're not talking about HMO insurance, indemnity policies or medicare only. These are people who hold private medical insurance.

Under the current law, for non-service-connected veteran inpatients, 13 percent of them have billable private insurance, and others have medical supplemental policies. For those that we serve that are outpatients, 41 percent have insurance that would be billable. Looking at that body, that would be the gross potential, of that approximately 60 percent of that total would be billable. That was an assumption that we made based on the fact that the veteran would not pay a copayment or deductible to the insurer. Essentially, the Government picks up that copayment or deductible by writing it off of the insurance bill, and also anything else that wouldn't be billed, such as a longer length of stay in the VA. So the potential is really 60 percent of the gross and then, looking at our estimates, we looked at how far we could implement the program.

Right now, we have peaked over the last 2 years at 19 percent of our potential. We are estimating that next year, given the fund, given the additional resources, we could reach approximately 50 percent of potential and ultimately, after a 5-year period, reach 90 percent of the potential. That 90 percent figure is based on estimates that we've gotten from the commercial sector: what they can do after they write off what they can't collect. So that is how we arrived at the estimates which you see before you.

Mr. STENHOLM. But that's not what I asked you. My curiosity is why—The second part of my question should have been, why not more attention paid to incentives to the local VA hospitals to do a better job of collecting and leaving a little bit of money with them? The free enterprise system works, but it seems that never comes into play in so many of our Government decisions.

Then the basic question is budgetary. Again, if you're looking at pure, free enterprise budgetary considerations, you don't start out by penalizing the agency. When you shift 500 people within an agency, there's a certain amount of punitiveness to that. You've given me the procedures that you looked at and how to collect it and the percentages and all. If there's a possibility to do that, it seems that we ought to be providing incentives to ourselves to do it. It seems to me that's not what your recommendation has been.

Mr. MCCANN. Mr. Stenholm, I think you need to consider the budget as a whole. The President's budget, as submitted, would add approximately 2,700 FTE over the level at which we were currently operating back when the budget was put together. It would take us up to the level that the Appropriations Committee has defined of approximately 194,600. In that context, we propose to shift the 500 that were already being used for that activity over to the medical care cost recovery. But there is a substantial net increase in the number of FTEs.

I would only add as a personal matter, that I strongly support the idea of providing incentives in the system. It is my view that I would like us to take one step at a time. Operating the revolving fund, getting it up and running, is a fairly complex process. I certainly would commit to the idea of talking to our colleagues in

OMB and elsewhere on the Hill, if it's successful, to see if we can encourage them to do that.

There are also ways in the execution of the budget that we can provide incentives to hospitals to do that, and I think with our new Chief Medical Director on board, I would be pleased to talk with him about that also. But I strongly support the concept of providing incentives.

Mr. ROWLAND OF GEORGIA. Thank you, Mr. Stenholm.

Mr. Kennedy.

Mr. KENNEDY. My questions were much along the same lines as Mr. Stenholm's. I just want to reemphasize that, as I understand this program at the moment, you have it so that the VA can keep about $25 million out of what is potentially a half-a-billion dollars worth of payments. Obviously, if you're running a local hospital and you're having to use personnel—despite the fact that you say 500 people at the moment are doing the billing—first of all, you're only collecting $100 million for all that work. Secondly, the VA, despite the fact that you answered Mr. Stenholm—If you want a minute of my time, you can go right ahead, Charlie.

The fact is, out of the 194,000 people that the Congress has suggested that the VA needs, we weren't anticipating the 500 that you sliced off to fulfill this purpose, so you're still 500 short.

One of the things that happens is that you start robbing Peter to pay Paul. Again, I want to emphasize that you should consider us allies rather than having to view us as somebody that's telling you the 500 positions that you've taken away from their normal administrative duties and shoved into this additional slot means that you have to live within the 194,000. I mean, if in order to fulfill the mission of the VA you need 194,500, then tell us that's what you need.

In addition, I don't see why you feel it's incumbent upon you to take OMB's decision about how they view this particular project. If we can bring some additional funds into the VA, then I don't understand why—For instance, on the housing committee, when we can bring additional sources of revenues into HUD by getting it out of the hide of the landlords or tenants, it certainly doesn't go back into the general fund. OMB isn't allowed to come in and take that money. It's a decision that you make, Mr. McCann, in anticipation of what OMB might do, rather than just doing what you think is right for your agency and letting us fight OMB about whether or not they have the right to come in and take the money back.

I guess I'm more or less trying to give you some encouragement to feel a little bit more confident about the fact that you've got some friends and allies on this side of the table, and that we ought to be helping you with some of those fights when you have to take them on with the administration.

I also wonder what you're thinking is when you've got a universe out there of a half-a-billion dollars and you're only collecting $100 million, what is the point of going after—I suppose increasing the universe is really what it comes down to—nonservice-related Category A veterans? I mean, why bother to take that battle on now if you can't even collect a quarter of the funds that are out there for you to get the job done at the moment?

Mr. McCANN. Let me back up for some of your earlier comments, Mr. Kennedy.

First of all, remember that the overall budget that we submitted this year is the largest increase in percentage terms or dollar terms that we've had for a long period of time——

Mr. KENNEDY. So what? The whole——

Mr. McCANN. It, in fact, decreases——

Mr. KENNEDY. Hold on. Excuse me, Mr. McCann. If you're going to come up here and tell us all the great things that the VA has done, we all know what the VA has done. We also know there isn't a single dollar that's going to be spent on additional health care as a result of that billion dollars. So don't come up here and tell us the platitudes about everything that you've done, please. Let's deal with the issues that are on the table.

Mr. McCANN. Please let me finish.

Mr. KENNEDY. Thank you.

Mr. McCANN. And it increases, by the way, faster than HI and medicare this year.

More importantly, if you look at the Indian Health Service budget, it established the way many people think we should be budgeted, which is that the Indian Health Service keeps all of the money it collects, approximately $100 million off of a budget of $1.2 billion.

However, the way that budget is negotiated—and I know, because I did it—you negotiate over the total budgetary resources. You face the Indian Health Service with the vagaries of its capacity to collect. If it collects more than it should, it does well, and if it collects less than it should, it doesn't do well. So there's an element of the vagary in that that we do not have in the VA system, even given the lateness by which we receive our appropriations.

There is yet another point, which is that one of the things we have tried to do is to insulate the treatment of the veteran from the decisions as to whether we are collecting money from him or not. If we make full availability or substantial availability of collected moneys available to the medical center, one of the things we have been concerned about is whether that might affect the way in which the veteran is treated at the hospital.

From the way we have structured the system now, from the point of view of the medical center, all veterans look the same.

Mr. KENNEDY. To be honest with you, I don't understand either point. I think the fact that you've worked in the Indian Health Service is terrific; you know, I admire the fact that you've worked there. I think that's just another arbitrary decision. Whether or not the Indian Health Service is able to keep funds and whether or not they're able to budget with the funds that they've kept is a separate issue from what we're talking about here with the VA. I appreciate the fact that you might feel that the way the Indian Health Service has done it is an appropriate way for the VA to do it. We could discuss that and get into that in some detail. But I don't think that's an appropriate answer to the question I just posed to you.

Secondly, for you to suggest that the administration at the local hospital is going to view all the patients as being the same doesn't get to the point of the question that I asked, which is why do you

go out and expand the universe on collecting a half-a-billion or whether it be $600 million? It doesn't seem to really get to the issue as to the fact that you haven't gotten even close to collecting the $400 million.

I'm sorry. My time has expired. But I didn't think the answers were——

Mr. McCANN. Quickly, Mr. Kennedy, I want to respond to the first part of your question.

With respect to the second part, we believe we have in place, or being put in place, a system which will collect far greater amounts of money from existing resources. We also believe that, from the point of view of consistency, and from the point of view of the best recovery for the Government, that it is an appropriate request to make to the Congress to be able to bill service-connected veterans for their non-service-connected admissions, because we do that in all other kinds of insurance. We do it for torts and we do it for a number of others.

Mr. KENNEDY. I was suggesting it was a little inappropriate at this time. That's all I was suggesting.

Mr. ROWLAND OF GEORGIA. The gentleman's time has expired.

Mrs. Patterson.

Mrs. PATTERSON. Thank you, Mr. Chairman. I don't have any questions at this time.

Mr. ROWLAND OF GEORGIA. Thank you.

Mr. Bilirakis.

Mr. BILIRAKIS. Thank you, Mr. Chairman. Just a couple. I apologize to the panel for my tardiness.

Mr. McCann, does H.R. 4935 allow the medical center to choose to contract for services or utilize its own personnel, for them to make that decision, and if so, will the medical center director be given the authority to make this determination, or will he or she require Central Office approval?

Mr. McCANN. As I understand the bill, it does provide the authority to contract for services, and we're presuming to use a menu contract.

As to its implementation, let me turn to Dr. Winship and maybe he can——

Mr. BILIRAKIS. But you do feel that the bill is flexible enough in that regard?

Mr. McCANN. Yes, sir, I do.

Dr. WINSHIP. Yes, I think that's exactly right. The needs of individual medical centers are different. I think the collections that we've seen so far, the kind of resources that individual medical centers have put into this operation so far is a strong indication that those needs are very different. We want to attempt to recognize those differences and to attempt to build into the system some guidelines about how the use of the menu contract should be carried out, but then leave it to the discretion of the individual medical center to use that contract as it sees fit to meet its own needs. We believe that will gain the most for us by the contracting out mechanism.

Mr. McCANN. Mr. Bilirakis, I would also call your attention—I believe before you were able to come—to a piece of legislation submitted by Mr. Conyers which would substantially reduce the Gov-

ernment's capacity to contract out for services and might substantially affect our ability to implement this through contracting.

Mr. BILIRAKIS. Well, when that piece of legislation progresses to a certain point, the VA certainly should notify all Members of Congress to that effect. That might be part of the decision-making process, obviously.

This flexibility that we've talked about is preferred to the VA, right?

Mr. MCCANN. Yes, sir.

Mr. BILIRAKIS. Can the practice of some insurers of discounting health care reimbursements to the VA be viewed as an admission by the insurers that the VA provides more cost-efficient care than the private sector? How do you all look at that?

Mr. MCCANN. Let me try to respond in two ways. Number one, we do have a problem with the fact that we bill on a per diem basis, which we believe is substantially below the payments that the insurers pay under other forms, either medicare or under private health insurance.

Mr. BILIRAKIS. So the "discount" then is a result of your billing?

Mr. MCCANN. Well, yes, that, but we also have a problem in that then they turn around and discount on our per diem, so we are, in a sense, being discounted on our discount. We have tried to submit to you some language that would clarify that.

Let me turn to my colleague and let him respond.

Mr. BRADSHAW. That's correct. It's a problem in a small number of cases so far with a relatively small number of insurers, but where it comes up, we really feel like we're not being treated the way the statute originally contemplated. But the language of the statute itself is somewhat unclear. That is why we proposed some clarifying language, to make the amount of the insurers' liability clear.

Mr. BILIRAKIS. Is this a unilateral thing on the part of the insurers? Can they just do this on their own?

Mr. BRADSHAW. It has been with the Blue Cross insurers. But it's their practice, I would say, in certain States to require a discount as a cost of doing business with private hospitals, and they are applying that same principle to us.

Mr. BILIRAKIS. I appreciate that that's the way it is ordinarily, and they're applying the same principle insofar as VA reimbursements go.

Very quickly—and I know we have a Journal vote—and maybe you can furnish the answer in writing to the committee rather than answering it——

Mr. ROWLAND OF GEORGIA. Yes. We have several questions that we want to submit, too.

Mr. BILIRAKIS. Then I won't bother to ask it at this point in time. We will just submit it for the record.

Mr. ROWLAND OF GEORGIA. We do have several questions that we want to submit to you for the record. What I had intended to ask has already been covered for the most part by other members of the committee.

I do want to put in the record a copy of the task force report on third party collections that you refer to in your statement, also.

[The report appears at p. 65.]

Mr. ROWLAND OF GEORGIA. I thank all of you very much for being here this morning. We will recess for approximately 15 minutes to vote.

Mr. MCCANN. Thank you, Mr. Chairman.

[Whereupon, the subcommittee was in recess.]

Mr. ROWLAND OF GEORGIA. The subcommittee will come to order, please.

The next panel of witnesses are Mr. Harry Guillote, Mr. John Haycraft, Ms. Jean Brown, Ms. Adrienne Frey-Jones, and Mr. Clint Gardner, if you will all take the witness table.

Mr. Gardner, I understand you have an opening statement but the rest of you do not. However, if you do want to make an opening statement, you will be recognized for that purpose.

Let me recognize Mr. Gardner first.

STATEMENT OF CLINT G. GARDNER, BIRCH & DAVIS ASSOCIATES, INC.

Mr. GARDNER. Good morning. First of all, thank you for the opportunity to present some information about medical accounts receivable collection in the Department of Veterans Affairs. I hope that the material I present today will help illustrate the magnitude of the VA's third party collections potential.

In April of 1988, my employer, Birch & Davis Associates, was engaged by the Richmond VAMC to study their billing and collections operations. We found that the VAMC had billed $5.9 million and collected $1.07 million, or 18 percent. We believe the VAMC could have billed $15.2 million and collected approximately $11.5 million of those dollars.

At the time the Richmond VAMC was ranked as the number one biller in the country by the VA. Yet, it was collecting less than one out of even ten dollars owed to it. Over 70 percent of the available but uncollected dollars at Richmond were related to insurance coverage.

First, the VAMC had not always identified NSC inpatient coverage; second, it did not always produce bills, even when coverage had been identified; and third, it did not have enough equipment or resources to bill for outpatient care.

Similar findings apply at other VAMCs I visited. The actions required to increase collections at Richmond and at these other VAMCs were, and remain, legal and practical. None would restrict the VAMC's health care mission.

The VA's collection opportunity is a direct function of the number of NSC veterans having private insurance coverage. Five expert estimates, three by the VA, one by GAO, and one by the PVA place inpatient insurance coverage from between 18 and 86 percent for all veterans and from 64 to 76 percent for veterans with an annual income of $15,000 or less.

Currently, there is a significant difference between the amounts that veterans pay to insurance companies and the amounts paid back by these insurance companies to cover the cost of care for veterans. This difference is, in effect, a subsidy by veterans to nonveteran insurance beneficiaries.

Two VA Administrators, the GAO, and the MCCR, which is the Medical Care Cost Recovery task force of the VA, and, interestingly, Dr. Holzinger in his 1981 master's thesis, have estimated the VA's total collection potential. These studies used different methodologies, different data, and relied on different definitions, to some extent to compare them as to compare apples and oranges. However, from low to high, these studies found that from $223 million to as much as $2 billion can be collected by the VA each year. Averaged, they suggest that the VA can collect about $796 million per year.

For perspective, these figures mean the VA could collect $4.6 million per year for each of its 172 hospitals, $3.06 million for every working day in the year, $2,300 for each NSC veteran who annually seeks care in the VA, or $7.9 million over a 10-year period, by implementing an effective billing and collections program.

Again, there are no technical or operational reasons why the VA cannot collect these third party reimbursements. There are, however, some significant obstacles that do prevent the VA from collecting these dollars. First, there are strong disincentives preventing VAMCs from devoting resources to third party collections. Second, the VA's automated accounts receivable system cannot compete in the private sector insurance claims arena. Third, VAMCs do not have enough billing and collections personnel.

These obstacles can be immediately overcome with a properly designed billing and collections program. Such a program should have the following characteristics:

First, it should call for integration of private sector accounts receivable technology, expertise and resources into the DVA. These skills and assets can be accessed immediately and can dramatically reduce the time required for the VA to realize its collections potential.

Second, it should permit contractors to be reimbursed only from the collections they generate; that is, contracts should be engaged "at risk". At-risk arrangements will provide powerful incentives for efficiency and make billing and collection operations largely self-managing. At-risk arrangements will also ensure that the VA will incur virtually no other program costs. This will be done by allowing them, in effect, to use the skills and assets of the private sector free of charge.

Third, it must allow a significant portion of the moneys collected to be kept by the VA, and fourth, a successful collections program must assure that the VA's budget will not be reduced dollar-for-dollar by the amount of money it retains.

In the final analysis, these medical claims owed the VA are legitimate and irrefutable claims by the Federal Government against large and well-established and often national insurance companies. There is no reason these dollars should not be collected.

I have submitted a brief overview of a no-cost, at-risk plan for contracted collection of medical accounts in the VA. I believe this plan will allow the VA to quickly and effectively collect the dollars owed it.

Thank you for the opportunity to share this information.

[The prepared statement of Clint G. Gardner appears at p. 114.]

Mr. ROWLAND OF GEORGIA. Thank you for your testimony.

Do any of the others have an opening statement or comment you wish to make before we begin questioning? (No response.)

Mr. Gardner, I just want to compliment you on the concise and complete background that you include in your testimony today. It was very helpful and very informative.

Let me ask the members of the pane from the field here, Mr. Gardner suggested that the private sector be contracted for some or all of the skills necessary to improve collections. Do you agree or disagree with that—anyone.

Mr. HAYCRAFT. I would like to be the first perhaps to say that I can't totally support Mr. Gardner's concept. I think some of the reasons would be that the very informed studies they did I believe may be 2 years old now. The people represented at the table can show you where they have demonstrated that the agency can do its own collections by virtue of the fact they now lead the field. We are now coming into a time where we can effectively collect moneys in a manner that we feel can support the proposals and the dollars involved without having to share any of this with an outside source.

So from our standpoint, or at least from my position at Little Rock, I feel we can do a very good job within the agency.

Mr. ROWLAND OF GEORGIA. Miss Brown, you have certainly established yourself as a very capable person in collections and have done an outstanding job, I understand. Do you have any comments on that?

Ms. BROWN. Yes. I agree with Mr. Haycraft. I think we can do an effective job without sharing the revenue with an outside source.

Mr. ROWLAND OF GEORGIA. Anyone else?

Let me ask the panel this. In your opinion, will there be enough incentive to maximize collections if the DVA is not allowed to keep an additional amount of the collections over and above the cost of such collections? Let's start over on the right.

Mr. GUILLOTE. I believe if the medical centers are allowed to at least cover the costs that they're incurring for third party collections, that will be an incentive. I think any additional dollars that they can gain above and beyond those costs will be a much greater incentive, if they're allowed to keep those dollars over and above the costs.

Mr. ROWLAND OF GEORGIA. Do you believe allowing some to stay in the DVA would be the proper thing to do then?

Mr. GUILLOTE. That will be a large incentive, yes.

Mr. ROWLAND OF GEORGIA. Miss Frey-Jones?

Ms. FREY-JONES. I have the same feeling that he has.

Mr. ROWLAND OF GEORGIA. Mr. Haycraft.

Mr. HAYCROFT. I have the same feeling. And, of course, I would like to expand it a little bit. That is, the dollars are important, and that would be a tremendous goal for each medical center, but it's also people that are important. It's people and labor-intensive system and we need both dollars and staff in order to be effective.

Mr. ROWLAND OF GEORGIA. Miss Brown.

Ms. BROWN. Yes, I agree.

Mr. ROWLAND OF GEORGIA. Mr. Gardner.

Mr. GARDNER. Actually, I'm not sure. I'm not a member of the VA and can't really answer that question. I have spoken to a number of people in the field who said that there were disincentives above and beyond simply keeping a portion of the money. The resources that are required conflict directly with the patient care task. To some extent, that condition will always exist, even if the cost of this care is recovered. There's a feeling that the program provides nothing to the VAMC. That's a rather strong feeling in some people's opinion. Also, just the overall complexity and scope of the work. It is a big job.

If I might, one recent thousand-bed hospital that we studied had approximately six people devoted to billing and collections. They were billing $5 million. This is not a VA hospital, by the way. It's a military hospital. They were billing $5 million and they could have billed $37.5 million.

The staffing plan that we drew for that hospital included some 35 to 40 people working full time on accounts receivable. These are not the kinds of numbers that I'm seeing in the budget that's been submitted or the kinds of staffing increases that have been talked about here today.

Mr. ROWLAND OF GEORGIA. Mr. Bilirakis.

Mr. BILIRAKIS. Well, I note with satisfaction and with congratulations that you represent the top three medical centers in terms of collections during the last quarter of 1989. To what do you attribute your success?

Ms. BROWN. In Martinsburg, we feel that we've been very successful because, from the beginning of the program in 1986, we committed ourselves totally to the program, although we only had one full-time employee at that time dedicated. The key officials went out and educated the service organizations. They went out to the membership and explained to them the program. They passed this on to the veterans. So we met with very little resistance.

Mr. BILIRAKIS. Maybe I can interrupt you at this point, Miss Brown. Have many of the other centers done the same thing, gone about it the same way?

Ms. BROWN. I don't believe too many of them did do that, especially early on. We went to local hospitals and found out how they did their billings. We did a lot of education of the employees. I think this helped us in our success.

Mr. BILIRAKIS. Any comments from the others? What did you do that might be somewhat different that attributed to your success?

Mr. GUILLOTE. I don't know how much different it is from what we do in Little Rock in the fiscal service. We do have one employee that works solely on third party in establishing the bills in the system and ensuring that followups and collections are promptly recorded. That is a key factor.

I believe another key factor is the fact that fiscal service and the medical administration work very closely together. When we receive a bill to mail out to the insurance carrier, the medical administration service provides us with policy information at that point in time, so when we receive collections, we can quickly identify whether it's a partial payment or whether it's a full payment. We handle the bills no more than absolutely necessary.

Mr. BILIRAKIS. That one person devoted strictly to this, is that individual taken from another area that might now be weakened as a result of——

Mr. GUILLOTE. No, sir. We absorb that within the——

Mr. BILIRAKIS. You absorb that adequately. Okay.

Ms. FREY-JONES. At the VA in Cleveland, we attribute our better collections to the fact of perseverance. We had a lot of bills that we sent out where you don't hear from the insurance agencies, no matter how many times you send them. It took more phone calls than anything to find out what was going on, what the problems were.

We have six individuals devoted to third party. We have two nurses, we have two individuals that do the bills, and we have two individuals that do all of the follow up. Just working together along with MAS, everything seems to come together now.

Mr. BILIRAKIS. Do you experience pressure, pushing, whatever the case may be, from the Central Office towards this end?

Ms. FREY-JONES. No.

Mr. BILIRAKIS. What is happening in the field in that regard? Are they really dedicated to this task? I guess that's a pretty tough question to ask of you all regarding your Central Office.

In other words, the testimony that has taken place before I arrived this morning I understand went pretty deeply into the fact that the efficiencies maybe haven't been there, the collections haven't been there that should have taken place. Do you have any comments towards that end without my actually raising a specific question?

Mr. GUILLOTE. I think the message is getting to the field, that medical care cost recovery is important and that we will have to follow through more so now than in the past. But the message is coming through loud and clear.

Mr. BILIRAKIS. Have you gotten any other medical centers contacting you and asking you to share your process towards success and that sort of thing? Have you run into much of that?

Ms. BROWN. That's an everyday occurrence with us. We get calls from all over the country. We have had many, many visitors that we've shared our program with. We would like to think it is helpful.

Mr. BILIRAKIS. Do you have the same experience, Miss Frey-Jones?

Ms. FREY-JONES. Yes.

Mr. BILIRAKIS. Mr. Gardner, could the limitations imposed by the Privacy Act interfere with contractor staff's access to computer information and thereby interfere with their ability to do their job?

Mr. GARDNER. No, sir. Directly analogous to the situation that I propose for contracting billing is the way in which fiscal intermediaries process CHAMPUS bills, for example. They have access to the entire range of data required to gather, produce and follow up on bills.

Mr. BILIRAKIS. So that won't be any problem?

Mr. GARDNER. No, sir.

Mr. BILIRAKIS. Mr. Chairman, in the interest of time, I won't go any further. I know the record is open for further questions to be submitted. Thank you very much.

Mr. ROWLAND OF GEORGIA. Yes, the record is open for questions.

I do have a couple of questions that I want to ask here. The GAO testified that VA clerks failed to ask the right questions about health insurance to veterans on admission and that veterans fear being turned away if they admit to having health insurance. Let me ask you, is the GAO correct in this?

Mr. HAYCRAFT. I would have to agree with them, from two standpoints. We think that is the critical issue in collections of third party insurance. Again, it was one of the reasons why I disagree with Mr. Gardner. We have to focus on getting the good information from our veteran patient when he first comes to us, and if we can do that, then that is the core to a successful system. This is done at the same time we register the patient in for health care.

I am unable to see how a private contractor could carve out time that we're already spending with the patient in order to elicit the insurance information for them to be successful. If we ourselves can get that information, then we can be very competitive in our billing, as we have demonstrated. I think early on the problems were in poor data collection, which relates to poor communication and poor education of our veteran patients. That is one of the things we're turning around now with the task force recommendations and what we've demonstrated that we can do.

In Arkansas, I don't think there's a fear any more and they are openly sharing with us, so we have demonstrated we can do it successfully.

Mr. ROWLAND OF GEORGIA. Let me go to Mr. Gardner then, because he has a joint project with Blue Cross and Blue Shield of North Carolina. Would you care to elaborate on that to the extent of how it would affect VA collections?

Mr. GARDNER. Yes, sir. First of all, the process that we're talking about is not just admissions. It's accounts receivable and it involves admissions, bill processing and ultimately collections. It is true that either the VA would—the whole process is dependent on the information that's initially gathered. So either the VA would require some training at the majority of the VAMCs that I've been to, or a contractor would have to be inserted.

But to respond more directly to your question, I have been teamed with Blue Cross/Blue Shield of South Carolina for about 2 years, studying and trying to get involved in this whole initiative. The reason they're interested, and the reason many people are interested, is they view it as an industry. They are the largest processor of CHAMPUS claims in the country. They have approximately 60 percent of the military CHAMPUS claims that come through.

The industry, to support the kind of initiative that we're talking about building from the ground up in the VA, is ready and waiting and quite adept at processing the kinds of claims that we're talking about here. They can process claims for two, three or four dollars a shot, whereas GAO found that a processed claim in the VA cost $27, one third party bill. These are the differences between, in my opinion, tapping into an existing industry and of creating a new industry.

Mr. ROWLAND OF GEORGIA. Why that much difference, do you think?

Mr. GARDNER. I think it's largely related to the accounts receivable automated system that supports billing and collection. For example, a good private sector system has things like front end audits that checks the bill before it leaves the building. If it's not correct, it doesn't go. That capability doesn't exist in the VA.

Now, I have been to Martinsburg, and these are definitely the best billers in the VA. So I don't want to make this sound like a bad thought. Oftentimes the bill will go out the door simply with a page audit, put and cross-put. The private industry is so much more sophisticated at that, they have front end audits on all digits. They check these against subsidiary payer data bases that say exactly how that compares once the information comes in, et cetera, et cetera. The result is you don't send a bill out the door with a stamp on it that takes three or 4 weeks to be turned around again and again. This is all done electronically and very quickly.

Mr. ROWLAND OF GEORGIA. I want to thank all of you. We have some additional questions that we will submit for the record. I do appreciate all of you coming very much.

Our next panel will be representatives from the veterans organizations: Mr. James Magill, who is from the VFW; Mr. Samuel Walsh, the American Legion; Mr. Frank DeGeorge from the PVA; and Mr. David Gorman from the Disabled American Veterans.

Gentlemen, I would ask you to limit your opening statements to 5 minutes, if you will. Your entire statement will be made a part of the record.

Let's start with Mr. Magill from the VFW.

STATEMENT OF JAMES N. MAGILL, DIRECTOR, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS OF THE UNITED STATES

Mr. MAGILL. Thank you for the opportunity to present the views of the VFW with respect to H.R. 4935. As you know, this legislation would provide for the recovery by the United States of costs of medical care and services furnished for a non-service-connected disability. Specifically, the measure would permit VA to recovery from health insurers the cost of care furnished to a service-connected veteran for treatment of a non-service-connected disability.

At this point I must emphasize that the VFW has in the past, and continues to have, reservations about utilizing non-Federal funds to pay for veterans health care. This, of course, includes third party reimbursement for VA for non-service-connected disabilities.

We strongly believe that it is a national responsibility to provide for the health care of its many military veterans. This was our position when third party reimbursement for VA health care was provided for in the reconciliation legislation of 1985 and continues to be so.

However, we did accede to the establishment of health insurer reimbursement to VA for non-service-connected injuries because of the desperate need for additional funding by the VA health care system at the time it was enacted into law. The dire funding problems besetting the VA health care system have certainly not lessened since that time and, if anything, the VA must now provide

even more veterans with increasingly expensive care with even fewer constant dollars than in past years. Thus, we continue to accept, although reluctantly, third party reimbursement of VA health care.

H.R. 4935, which permits the VA to recover the cost of care furnished to a service-connected veteran for treatment of a non-service-connected disability, is something which we may not accept as written. We believe that all Category A veterans should be excluded from any such proposal. We would, however, not object to the reimbursement of VA health insurers of those B and C category veterans.

The bill before us today would also create a third party medical recoveries fund which would be separate and apart from the medical care account. The VFW believes that at least a given percentage of any excess revenues should be turned back into the health care system on an annual basis, with no offset of fiscal appropriations.

One other point. The VFW also notes that the fund would be initially staffed and funded with up to 500 FTEs and a $18.6 million transfer from the medical care account already devoted to third party recoveries. We believe this fund should instead be established through a separate appropriation and not through the reduction of the medical care account. The 500 employees are not now exclusively dedicated to cost recovery and have other responsibilities within the Department. Thus, VA cannot afford to completely lose the service of these health care employees.

Mr. Chairman, this concludes my statement. Once again, I wish to thank you for inviting us. I will be happy to respond to any questions you may have.

[The prepared statement of James N. Magill appears at p. 121.]

Mr. ROWLAND OF GEORGIA. Thank you, Mr. Magill.

Mr. Walsh.

Mr. WALSH. Thank you, Mr. Chairman. With me this morning is Mr. Frank Buxton, who recently joined our staff as Deputy Director of our National Veterans Affairs and Rehabilitation Commission. He will be presenting our summary statement this morning.

Mr. ROWLAND OF GEORGIA. Thank you.

STATEMENT OF THE AMERICAN LEGION, DELIVERED BY FRANK C. BUXTON, DEPUTY DIRECTOR, NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION; ACCOMPANIED BY SAMUEL J. WALSH, DEPUTY DIRECTOR, NATIONAL LEGISLATIVE COMMISSION

Mr. BUXTON. Thank you, Mr. Chairman, and members of the subcommittee. We appreciate the opportunity to offer the American Legion's views on proposals relating to H.R. 4935 and the means test and third party insurance programs.

In regard to H.R. 4935, the American Legion opposes any legislation which would substantially alter the current law under which service-connected veterans are exempt from third party recovery for treatment of non-service-connected disabilities. However, realizing that this program is the law of the land at the present time, the American Legion does support the authority for all VA medical

centers to retain the costs of processing claims through third party reimbursement.

We have also been invited to comment on issues raised in two recent General Accounting Office reports, the first report entitled "Medical Centers Need to Improve Collection of Veterans' Copayments". This report examines the means test billing and collection procedures. In order to collect a greater amount of overall billings, the GAO recommends that the VA make payment arrangements while the veterans are still at the centers. Also using fiscal year 1988 data, the GAO projected means test collections that exceeded the cost.

Mr. Chairman, the American Legion opposed enactment of the means test as legislation that was unnecessary and inappropriate. Experience over the last 4 years since its enactment has established a number of problems with the means test program. It is our view that the GAO recommendation to the Secretary will not rid the program of its inherent weaknesses but will only serve to compound its failures.

The GAO report issued in March, 1990 is based on fiscal year 1988 data. It is the view of the American Legion that if this study were based on fiscal year 1990 data, the results would be much less supportive for continuing the means test program.

While comparing fiscal year 1990 to fiscal year 1988, the number of Category C veterans for which copayments apply has roughly halved in those two short years. Attempting to implement the GAO recommendation to bill or to make arrangements for copayment prior to veterans being discharged from VA facilities, or at the time of receiving outpatient care, will only increase the staff demands. The cost of administering the means test for the most part reduces available medical care funding.

The American Legion believes it's time to repeal the administrative requirements of the means test. In our view, the program is discriminatory and further conduct of the program in its present form will only reduce the amount of funds available for direct payment care, at no appreciable benefit to the United States Treasury.

Mr. Chairman, the second GAO report on which we have been invited to comment is entitled "Better Procedures Needed to Maximize Collections From Health Insurers", issued in April, 1990.

The GAO offers several recommendations to the Secretary of Veterans Affairs to increase billings and collections for medical services provided to insured veterans. Since we have commented on our opposition to H.R. 4935, we will suffice to say that the American Legion opposes the concept of billing service-connected veterans for non-service-connected health care.

Over the past several years, the VA has not met its third party recovery goals. Now, as fewer Category B and Category C veterans are receiving VA health care, reducing the pool of insured veterans, new sources for meeting the VA's cost recovery goals are sought. It is totally out of line in the view of the American Legion to suggest that third party billings be applied to any service-connected veteran, especially those veterans who are statutorily entitled to vote VA inpatient and outpatient care.

Mr. Chairman, that concludes our statement.

[The prepared statement of the American Legion, delivered by Frank C. Buxton, appears at p. 124.]

Mr. ROWLAND OF GEORGIA. Thank you.

Mr. DeGeorge.

STATEMENT OF FRANK R. DEGEORGE, ASSOCIATE LEGISLATIVE DIRECTOR, PARALYZED VETERANS OF AMERICA

Mr. DEGEORGE. Thank you, Mr. Chairman.

PVA, too, wishes to thank you for inviting us to present our testimony here today.

Mr. Chairman, in this time of fiscal restraint and growing budget deficits, we can understand the need for DVA to seek alternative methods of revenue enhancement. However, this proposal to collect receipts from third party payers for the cost of medical care to service-connected veterans for non-service-connected disabilities is clearly not in the best interest of the Department, the veteran population, or the public. We see this proposal as another in a long list of options designed to increase fees, copayments, and reimbursements requiring the veteran to continue to pay more and more for services which historically have been provided by the Federal Government.

As the veteran population rapidly ages, the number of veterans holding private health insurance policies from which DVA may collect reimbursements will significantly shrink.

By expanding collections from third parties for the cost of medical care, DVA is establishing a dangerous precedent which could increase health care insurance premiums to the population as a whole. In this case, the expense of care is shifted to the private health insurance sector. These insurers, in turn, must shift the cost burden to the Nation's health care policy holders, whether they be disabled veterans or not.

The Department states that this proposal is necessary in order to make their third party medical care cost recovery program more consistent. Mr. Chairman, by attempting to make this cost recovery program more consistent between service-connected and non-service-connected veterans is no reason at all to change existing law. Title 38, USC, mandates that service-connected disabled veterans rated 50 percent or more are entitled to medical care and services provided by the Department regardless of insurance status. This law clearly demonstrates that veterans with service-connected disabilities have the highest degree of priority within the DVA system. Requiring collection of third party receipts for the cost of medical treatment currently provided under existing law would undermine historic legislative intent established in title 38 and be a serious breach of commitment to our Nation's veterans.

While PVA would support an enhanced budget to aid in third party collection, we encourage the establishment of a procedure in which funds collected will be deposited into the DVA medical care account to improve health care for eligible veterans, as opposed to these funds being deposited into the general account of the U.S. Treasury. At the present time, however, DVA could withhold some of these collected funds but would undergo the risk of having

future budgets offset accordingly by the Office of Management and Budget, making this proposal unworkable at this time.

Despite assurances to the contrary, we do not believe a concrete formula has been derived to secure the receipt of these third party payments by DVA in order to enhance medical care programs. If the current Secretary and the current Director of OMB have reached such an agreement, and if this agreement is sound and firm, then PVA urges the same agreement be expanded to allow DVA to keep all third party receipts.

Regarding section 4, the transfer of employees and funds from the medical care appropriation, PVA expresses great concern over this particular provision. DVA is in the middle of a funding crisis, a crisis in which medical centers are curtailing programs and services due to a lack of funding. We note that although this collection program is a priority of the administration, proposed fiscal year 1991 appropriations do not provide specific authorization for an additional $18 million for this purpose. Regardless of the amount of funds anticipated to be recovered, this transfer of FTEE and funds in fiscal year 1991 will create a serious drain on an already overburdened system. In other words, placing DVA in the role of bill collector will potentially decrease resources available to provide medical care to our Nation's veterans now and in the future.

Mr. Chairman, we support DVA's efforts to follow current law. Since DVA is mandated to pursue the collection of third party payments for the cost of medical treatment provided to certain nonservice-connected veterans, the Department should be provided adequate resources to carry out this stipulation. However, we have previously stated our concern over the return to the Department of any receipts from third party collections. Despite agreements and understandings with OMB to the contrary, we remain concerned that OMB will use these collection offsets to decrease funding for needed program costs in future budgets.

Finally, Mr. Chairman, PVA supports enhanced efforts to collect copayments from Category C veterans.

That concludes my statement at this point.

[The prepared statement of Frank R. DeGeorge appears at p. 130.]

[The prepared statement of David W. Gorman appears at p. 134.]

Mr. ROWLAND OF GEORGIA. Thank you very much.

You've heard me express my concern about the future of our health care system in the VA, and concern about hospital beds that were not occupied, a concomitant reduction in staff because they weren't being used and the staff wasn't necessary. It sets up a vicious cycle.

We have seen some horizontal cuts take place, with directors being absolutely pushed to the wall to try to meet their responsibilities. I think it has only been through the dedication of people that work in those hospitals that we've been able to maintain the quality of care. I don't agree with the article I saw in the paper regarding the quality of care for the most part.

I guess one thing that really focused my attention on this was what happened in my own home of Dublin, GA. There was an effort there to close a surgery unit in that hospital. Perhaps you're

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aware of that. This has also come about in some other hospitals in the more rural areas of our country.

I was told by the medical personnel in that hospital, that if the surgery unit closed, it would be increasingly difficult for internal medicine personnel and others to stay there, because it's also very much interrelated.

So I see a struggle now with the budgetary constraints that we have. I feel that our system, in the not too distant future, is going to be really in jeopardy.

Let me ask you, is this a legitimate concern that I have? You mentioned the lack of funds as being one of the reasons for that. Should we be looking for ways to increase funds coming in so that we can sustain the system, even if it necessitates some mix, other than the system being totally autonomous like it is now? What is your thinking about that?

Mr. MAGILL. I think your fears are not unfounded and your concerns are not unfounded. I think one of the basic problems—and it's going to take the work of the veterans organizations—is we have got to have a good starting figure coming out of OMB on the budget. This has been the problem, I think, from day one, where the administration has not provided VA with the funds that they need to properly care for the veteran.

If we can convince the administration, and particularly OMB, that they have got to give the VA a good solid shot in the arm, and then continue not to provide a decremental budget each year, I believe that would alleviate some of the problems that we have right now.

Mr. WALSH. From The Legion's perspective, we certainly agree with Jim, that there is a major problem there. We are, however, mandated to oppose these third party reimbursements. One basis for that certainly is the fact that OMB is going to recognize a lot more income than we certainly believe will ever be generated. So we just see the hole getting deeper. We really don't see the infusion of funds from other sources as being particularly helpful in the long term.

I wish I could offer you a better solution or a better answer than that, but that's all I have to offer right now.

Mr. DEGEORGE. Mr. Chairman, I would agree with my colleagues. Regarding Jim's statement about a shot in the arm for the budget for the Department of Veterans Affairs, I wholeheartedly also agree with that. But I think you can't give it a one-time only shot in the arm. We should also look at the long-range forecast to say, in the second, third, fourth and fifth year, we'll provide "X" amount of dollars to give the VA a shot in the arm and get it back on track.

Mr. ROWLAND OF GEORGIA. How do we get OMB to do that, though? You know, we've been struggling with this, as you well know, for several years now. We just have not been successful. Well, we did get a little more money this go around, about a billion dollars, but we've just been unsuccessful in doing that.

It is your feeling, then, that we should continue to try to convince OMB to bail the system out, I guess you might say, or to prevent the system from deteriorating any further, rather than to go to some other source?

Mr. WALSH. Again, from The Legion's perspective, we certainly do. Where we see a continual problem over the last several years is there is no certainty. There seems to be a bunch of money and then it disappears. Either Gramm-Rudman will kick some in or something else, and then we don't have enough money. So the hospitals trim back, and then there's a resurgence of moneys. It's just a constantly going up and down. We need to correct that situation. I think getting OMB on line with the administration perhaps is the first solution.

Mr. MAGILL. If I could just comment on one thing, on my previous statement, when I was talking about the shot in the arm, I did not mean to imply that it would just be a one-time deal. What I mean was that they have got to give a very substantial increase in funding immediately, followed up by funding at a level that will maintain the VA's ability to give proper care.

Mr. ROWLAND OF GEORGIA. How do we get OMB to do that?

Mr. DEGEORGE. Mr. Chairman, I have a suggestion. When your committee members visit the VA hospitals, take a few OMB members along with you to see what's going on.

Mr. ROWLAND OF GEORGIA. Do you think we could get them to go?

Mr. DEGEORGE. If you already haven't done that, that is.

Mr. ROWLAND OF GEORGIA. I believe my time is up.

Mr. Bilirakis.

Mr. BILIRAKIS. Thank you, Mr. Chairman.

Frank, your comments—and I know you speak for all the group—that this additional money that would be coming in as a result of third party insurers and payers would merely be offset, if you will, by virtue of a reduction in other funding, I would like to think that would take place over our dead bodies. I hope that obviously that is not the plan. You're speculating that it would, and I know you've had an awful lot of past experience which leads to that speculation.

We on the Veterans' Committee have been a pretty good buffer, we like to think. I don't know that we've done the job as well as maybe we could have, but when it comes to the administration budgets, for instance, we've always tossed them asunder and increased them. But we can't do any job without you; you know that. We've worked together on other areas, particularly on 303. We haven't gone very far on it, but we've worked together on it. And this committee has not been very helpful, for the record, in this regard.

But as far as the budget is concerned, how much do you all lobby the members of the Budget Committee? Do you lobby them, do you attend their budget hearings, do you attend their budget markups? Do you do the things that you basically do with this committee? You also know the limitations of this committee when it comes to money. We can get out there and fight, but they're the ones who make the ultimate decision. We can talk about OMB, and we do, but it is still the Budget Committee that ultimately comes up with the decision. By virtue of the Constitution, Congress appropriates the money, regardless of what OMB may do.

Mr. MAGILL. As far as the Budget Committee, I think it should be stated that this is just the second year that we've even been in-

vited to come in and make comment at hearings. I can assure you that the Veterans of Foreign Wars—and I know I've been with other veterans groups—have met personally with almost all the members of the Budget Committee or their staff. We have been doing the same thing with the Appropriations Committees. We've been running all over the halls of this Hill. The problem that we're encountering is a reluctance on the part of the Budget Committee to give us the time that we think we deserve with them to represent the veterans.

With respect to OMB, I can only speak for the Veterans of Foreign Wars, but we have repeatedly asked to meet with Darman and we have been flatly refused every time. We can't even get in to see a staff member. That's where we're running into the problem.

Mr. BILIRAKIS. Is that the experience that all of your organizations are having?

Mr. DEGEORGE. Mr. Bilirakis, PVA has testified before the Budget Committee both in the House and the Senate. I would add that we've worked and provided testimony before the Appropriations Committees on both the House and Senate over the last four to 5 years. In fact, we spend a fair amount of time meeting with people on both committees of the House and Senate.

Mr. BILIRAKIS. Have you had a little better success than the VFW in terms of——

Mr. DEGEORGE. In fact, we feel like in certain years, with the work of your committee, the House Veterans' Affairs Committee, in conjunction with them, and going to the Appropriations Committees, that we were able to get increases by meeting with them. Again, a large part of that work comes on the good efforts of this committee right here in the House.

Mr. BILIRAKIS. Sam, did you have anything you wanted to add?

Mr. WALSH. Yes, sir. This year I think we've all been a lot more successful than in years past, and I attribute that to the independent budget, which has been very, very helpful. Although the American Legion is not a participant in the budgets, it provides a point of reference other than the administration's proposal and it's very helpful to everybody.

We have had tremendous success this year in dealing with the Appropriations Committee and the Budget Committee. I think, collectively, all the veterans organizations have mounted a more effective, grassroots lobbying effort than has been done in the past. I believe, although we haven't coordinated with one another as to our activities, we have certainly kept the veterans informed so that we all know what everybody else is doing.

With respect to OMB, I can't comment from The Legion's perspective. I have had no contact with them, and my shop hasn't, but perhaps somebody else has.

Mr. BILIRAKIS. As Dr. Rowland alluded to, we have got to face the real world here. You know, there are concerns about the means test. One of the concerns was it would raise insurance premiums. Do you all have any evidence of substantial increases in premiums as a result of what was done regarding the means test?

Mr. MAGILL. No.

Mr. BILIRAKIS. Very quickly, because our time is about up. There is a point here I would like to make, Dr. Rowland, if I may.

Go ahead, Jim.

Mr. MAGILL. No.

Mr. BILIRAKIS. Mr. Walsh.

Mr. WALSH. No.

Mr. DEGEORGE. I believe we have some evidence, but let me get back with my office and see if we can't provide it.

Mr. BILIRAKIS. You think there may be some evidence of that?

Mr. DEGEORGE. Let me give you a definite answer.

Mr. BILIRAKIS. This has been in effect since 1986. Do we have any evidence of increased premiums as a result of the billing of their party payers, third party insurers? Do we have any evidence of increased premiums?

Mr. MAGILL. Not that I know of.

Mr. WALSH. I'm not aware of any, sir.

Mr. BILIRAKIS. So we're talking about insurance companies which have, as I see it, gotten the benefit of the fact that a particular insured of theirs is a veteran and is eligible for medical care at one of the medical centers, outpatient clinics or whatever, and that insurer has gotten the benefit of not having to pay out for that medical care. Isn't that true? I mean, wouldn't you say that insurers have gained the benefit of this all through the years? They haven't had to reimburse anybody for that medical care that they ordinarily would have to reimburse somebody for.

Mr. DEGEORGE. Well, that's what we envision. That's the point of our comment in our testimony. But also, while the insurance companies might benefit, it is going to come back to the full public and cost them more money.

Mr. BILIRAKIS. But, Frank—You know, I don't have to explain our credentials to you and where our heart lies on this committee. I think we're all on the same wavelength as far as all of these areas are concerned. We're all concerned with the veteran.

But basically, similar comments were made, with all due respect, regarding the means test, and we haven't seen an increase in premiums take place. We apparently are not aware of an increase in premiums taking place since 1986 when this third party insurer concept came into being. So we're still speculating that that will take place. If it does take place, I think we ought to address it, have oversight, and we should stay on top of it, that sort of thing.

I also see merit in your argument that maybe it would take time away from proper medical care, if you will, and personnel who ordinarily would be doing other things that would be benefiting the veteran, taking them away and maybe putting them into the collection process and that sort of thing. I guess that makes a little bit of sense, although again we haven't heard any testimony to that effect. One of the top three medical centers indicated they have one person full time doing this, and then his or her job, whatever, has been absorbed.

I guess what I'm really saying is that—you know, the budget summit is taking place right now. We don't know what the result of that is going to be. But then you have budget reconciliation and the Budget Committee mandates to various committees to make certain cuts within that budget reconciliation process. If we're mandated to make a half-a-billion dollars in cuts, should we have cuts or should we replace those cuts, in effect, with this $400–500

million or more that maybe we can get from these insurance companies, who as I see it have been getting the benefit of not having to reimburse for medical care that ordinarily they would if this were not a veteran going to a medical center.

Do you have any quarrels with my comments?

Mr. MAGILL. The only thing I would comment on, Congressman, is that you commented that—true, we have not heard of vast increases in premiums. But then, at the same time, I think it should be brought out that I don't think VA has been that aggressive in trying to get third parties.

What we thought up in my statement, we said, if you were referring to us, that we think there is the possibility that increases could go up. If the VA should become more aggressive in billing insurance companies, then we are just saying now there is the possibility that that would happen.

Mr. BILIRAKIS. Well, Jim, sure there's a possibility that that would happen. But at the same time, if we are faced with cuts here, and we will fight them with all of our being—I think we have in the past—but if we lose out, which has basically happened every year in the past, every year since I've been up here, should we just go ahead and accept those when, in fact, we may have a way—provided, now, we don't have this offset that Frank mentioned, and all of you feel strongly about—and I worry about that, too—where the OMB and the Budget Committee will offset it and say, "Oh, what the heck, they're getting a half-a-billion coming in from third party insurers, so we'll go ahead and make the cut." You know, we would fight against something like that.

Should we be faced with just accepting these cuts when, in fact, we've got insurance companies out there that are collecting premiums that they ordinarily would be paying out if it were not a veteran who qualifies for medical care and that is good money sitting there which would come in and hopefully more than replace any prospective cuts.

It's the real world, I think.

Mr. DEGEORGE. In regards to that——

Mr. BILIRAKIS. Sam says no, not the real world, right?

Mr. DEGEORGE. Another consideration that we're fearful of is that veterans will not be able to get insurance based on their disability and aging process, given that the insurance companies will be expected to pay out more.

Mr. BILIRAKIS. In other words, as long as——

Mr. DEGEORGE. I mean, that's a potential for——

Mr. BILIRAKIS. As long as the insurance companies receive the premiums and don't have to make any payouts, they're going to be willing to go ahead and give the veterans the insurance, right? But they might not be willing to give them out if they have to have payouts? I would hope we could prevent things like that from happening.

Mr. WALSH. I have just two quick points to make. I'm not in disagreement with you, Congressman. On principle, the American Legion opposes the entire concept of making any insurance company pay anything with respect to treatment in the health care facilities. But to assume that the insurance companies are getting rich, they're not getting rich. I mean, if they're not paying out the

money, or if they were to pay out the money—I'm not selling for the insurance company, but they would simply raise premiums. They have a better taxing system than the IRS. They just adjust a buck here and a buck there and in no time at all it's compensated for.

The fact that insurance companies are not paying out, one can't assume that they're getting real rich on America's veterans.

Mr. BILIRAKIS. I'm not attacking the insurance companies, and I'm not saying they're getting rich. But I am saying we've got a history of $100 million last year and the premiums haven't gone up apparently. I'm not saying it's made the poor and I'm not saying they're getting rich. I guess what I am saying is that we've got some real world type problems here and I honestly feel we ought to be working together to try to solve those problems. If there is a pool out there—if there is, and maybe it's a false pool, because maybe your point is a good one; they may not just insure the veteran and refuse to insure the veteran if they've got to have the reimbursement. But if there is a pool of money there that can be helpful and be used towards the medical care of our veterans, then, by gosh, I think we're pretty darned foolish to pass it up.

You know, you've got your job to do, and I'm very interested in hearing your comments here. I just don't know that I've really heard—I've heard speculative reasons on your part, speculating that such and such will take place—and it might. It very well might. I don't know. I would like to think not.

By the way, Mr. Chairman, with your further indulgence, General Peck, the Director of the Department of Veterans Affairs in the State of Florida, just walked into the room and I wanted to recognize him. General, welcome to Washington.

Mr. ROWLAND OF GEORGIA. Thank you, Mr. Bilirakis.

I think the gentleman from Florida makes an excellent point. That's one of the things I'm concerned about. If that money, in fact, is out there, while I would prefer to see care for veterans financed totally through Federal funds—and that's what you mentioned earlier—it doesn't seem to me that's going to be the way it's really going to work. It hasn't. We have seen the decrease in funding relative to the Consumer Price Index over the past several years. If that money is out there, why don't we go after it? I mean, why don't we use it to make up some of the shortfalls that we have?

Now, it may be that the insurance companies are not getting windfalls. I don't know. But maybe that money is being used to subsidize the health care of people who are not veterans. Maybe it's going in that direction. But as the gentleman said, if you're paying an insurance premium and you never use the insurance, that's sort of to the advantage of the people selling the insurance. I mean, that's a real good deal for them. I guess we could beat this dog a long time, couldn't we?

I want to thank all of you for being here this morning. I appreciate the testimony you have given. I think this has been an excellent hearing. I think we focused attention on an area that needs to be given more consideration. And I thank the gentleman from Florida for being here.

[Whereupon, at 11:20 a.m., the subcommittee adjourned.]

APPENDIX

101ST CONGRESS
2D SESSION

H. R. 4935

To amend title 38, United States Code, to provide for recovery by the United States of the cost of medical care and services furnished for a nonservice-connected disability, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

MAY 24, 1990

Mr. MONTGOMERY (for himself and Mr. STUMP) (both by request) introduced the following bill; which was referred to the Committee on Veterans Affairs

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A BILL

To amend title 38, United States Code, to provide for recovery by the United States of the cost of medical care and services furnished for a nonservice-connected disability, and for other purposes.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. (a) This Act may be cited as the "Medical Care Cost Recovery Amendments of 1990".

(b) Except as otherwise specifically provided, whenever in this Act an amendment is expressed in terms of an amendment to a section or other provision, the reference shall be

considered to be made to a section or other provision of title 38, United States Code.

SEC. 2. Subsection 629(a)(2)(D) is amended to read as follows:

"(D) that is incurred by a veteran who is entitled to care (or payment of the expense of care) under a health-plan contract.".

SEC. 3. Subsection 629(c)(2)(B) is amended by striking out "in accordance with the prevailing rates at which the third party makes payments under comparable health-plan contracts with", and inserting in lieu thereof "if provided by".

SEC. 4. Subsection 629(g) is amended to read as follows:

"(g)(1) There is established in the Treasury of the United States a separate fund to be known as the Department of Veterans Affairs Third Party Medical Recoveries Fund (hereafter referred to in this section as the 'Fund'). The Fund shall be established with collections from third party medical care cost recovery activities and be available to the Secretary, to the extent provided for in advance in appropriations acts, for necessary expenses for the identification, billing, and collection of the cost of care and services furnished under this chapter. Such necessary expenses shall include personnel and administrative costs (including costs of equip-

ment, computer hardware and software, word processing and telecommunications equipment, supplies and furniture, and personnel training and travel), the costs of any contract for identification, billing, or collection services, and any other necessary expenses. The Fund shall also be available to reimburse the Secretary for such services and utilities, including light, water, and heat, as the Secretary may furnish for its activities. Reasonable charges, to be determined by the Secretary, shall be paid by the Fund for the services and utilities so furnished.

"(2) The Secretary may transfer to the Fund in fiscal year 1991 from the Medical Care Appropriation such full-time equivalent employees (not to exceed 500 full-time equivalent employees) as have heretofore been devoted to third party medical recovery activities and funded from the Medical Care Appropriation, and sufficient funds to pay the first-year salaries of such employees and related costs (not to exceed $18,600,000).

"(3) By January 1 of each year, there shall be deposited into the Treasury of the United States as miscellaneous receipts an amount equal to the greater of the unappropriated or unobligated balance remaining in the Fund at the close of the prior fiscal year.".

SEC. 5. Subsection 629(i)(1)(A) is amended by adding at the end thereof the following new sentence:

"For purposes of this section, such term includes a Medicare supplemental insurance policy as defined in section 1882(g) of the Social Security Act (42 U.S.C. 1395ss(g)), and with respect to such a policy, Department of Veterans Affairs medical facilities and personnel shall be deemed Medicare-participating providers, and medical services covered by such a policy and furnished by the Department of Veterans Affairs shall be deemed Medicare-covered services.".

SEC. 6. This bill shall take effect on October 1, 1990.

Statement of

Hon. John Paul Hammerschmidt
Ranking Minority Member
Subcommittee on Hospitals & Health Care
Regarding Third Party Reimbursement

June 20, 1990

Mr. Chairman and Members of the committee. This subcommittee will turn its attention today to a matter which may have a profound effect on future health care delivery in department of veterans affairs medical centers. The issue of third party reimbursement for medical care received in VA medical centers is still relatively new. The first legislation to authorize collections from third party payers was contained in public law 99-272, only 4 years ago.

Prior to that time, the Department of Veterans Affairs had no experience in the area of billing and debt collection. As would be anticipated by the nature of the Department's inexperience, the success of such collections varies greatly across the nation. The Department recognizes that such variation is a symptom that the system is in need of improvements.

One of the bills we have before us today, H.R. 4935, Contains the Administration's own recommendations for improvements to the VA's medical care cost recovery program.

This subcommittee also has introduced legislation designed to make improvements to the ability of the VA to collect from veterans' insurance companies. Provisions contained in H.R. 901 Which passed the House last session are still pending in the Senate. The Senate too has its own version of third party legislation.

In March and April of this year, the General Accounting Office completed two reports which highlight the need for the Department to improve its collections from both health insurers and veterans' copayments. We will hear testimony from the GAO on its specific findings later today.

Mr. Chairman and Members of the committee, it is obvious that the Congress, the Department, and the GAO recognize the importance of improving the VA's methods of collection, though our approaches vary. Today's hearing will focus on these various approaches and hopefully we will be able to reach some consensus about the best way to proceed.

We will also hear from the veterans whom such changes will affect. It is important to receive their views and recommendations on the various proposals we have before us. And finally, we will hear from interested individuals outside of the VA.

Mr. Chairman, I believe we have a very complete list of witnesses and I commend you for calling this hearing. I am hopeful that after a thorough review of the issue, we will be able to proceed in a manner which reflects the best interests of the department and the veterans it serves.

I welcome our distinguished witnesses and look forward to their testimony. Thank you mr. Chairman.

OPENING STATEMENT

THE HONORABLE BOB McEWEN OF OHIO

SUBCOMMITTEE ON HOSPITALS & HEALTH CARE

COMMITTEE ON VETERANS AFFAIRS

JUNE 20, 1990

THANK YOU, MR. CHAIRMAN.

I WANT TO COMMEND THE CHAIRMAN FOR HOLDING TODAY'S HEARING, SO THAT WE MIGHT MORE CLOSELY EXAMINE AN IDEA WHICH IS NOT NEW, BUT WHICH MAY HOLD SOME PROMISE FOR OUR VETERANS HEALTH CARE SYSTEM.

IN AN AGE OF NECESSARY DEPARTMENT-WIDE BUDGET CONSCIOUSNESS, THE ISSUE OF THIRD-PARTY REIMBURSEMENT IS ONE WHICH CLEARLY DESERVES OUR THOUGHTFUL CONSIDERATION.

TODAY, OUR VETERANS HEALTH CARE SYSTEM IS FORCED TO MAKE PRECIOUS DOLLARS GO FURTHER THAN EVER BEFORE. ANYTHING WE CAN DO WHICH MIGHT INCREASE THE NUMBER OF DOLLARS AVAILABLE FOR VETERANS HEALTH CARE CERTAINLY SEEMS WORTHY OF A CLOSER LOOK. THIRD-PARTY REIMBURSEMENT AT LEAST HOLDS THAT POTENTIAL, SUPPLYING AMPLE JUSTIFICATION FOR THESE PROCEEDINGS.

I AM PLEASED TO WELCOME DISTINGUISHED WITNESSES FROM THE GENERAL ACCOUNTING OFFICE, THE DEPARTMENT OF VETERANS AFFAIRS AND A REPRESENTATIVE FROM THE PRIVATE SECTOR -- EACH OF WHOM HAS VALUABLE INSIGHTS TO SHARE ON COLLECTIONS OF THIRD-PARTY MEDICAL ACCOUNTS RECEIVABLE.

IN ADDITION, WE ARE FORTUNATE TO HAVE WITH US REPRESENTATIVES OF THREE OF THE VA MEDICAL CENTERS WHICH HAVE MADE A

SPECIAL EFFORT TO IDENTIFY PATIENTS WITH INSURANCE, AND TO BILL INSURERS. THEIR IMPRESSIVE RESULTS HAVE HELPED GENERATE MUCH OF THE INTEREST OF THIS COMMITTEE ON THIRD PARTY COLLECTIONS. I'M CURIOUS TO KNOW HOW THEY GO ABOUT COLLECTING THESE REVENUES.

I'M ESPECIALLY PLEASED TO WELCOME ADRIENNE FREY-JONES FROM THE CLEVELAND VA MEDICAL CENTER, ALONG WITH OUR FRIENDS FROM LITTLE ROCK AND MARTINSBURG.

FINALLY, I AM PLEASED TO WELCOME OUR FRIENDS FROM THE VETERANS ORGANIZATIONS, WHOSE OPINIONS AND WORK ARE INVALUABLE US.

NOW MR. CHAIRMAN, I'D LIKE TO WELCOME OUR WITNESSES TO SHARE THEIR VIEWS ON THE PRACTICE -- AND POTENTIAL -- OF THIRD-PARTY REIMBURSEMENTS. THANK YOU.

REP. CHRIS SMITH, NJ

VETERANS AFFAIRS SUBCOMMITTEE ON

HOSPITALS AND HEALTH CARE

HEARING ON THIRD PARTY REIMBURSEMENT

JUNE 20, 1990

Thank you, Mr. Chairman.

Mr. Chairman, I appreciate your arranging today's hearing to review the VA's Medical Care Cost Recovery program and HR 4935, legislation to expand the program. It appears as though the VA is eager to improve and carry out its collection of third party reimbursement payments. This hearing, I believe, will enable us to explore the advantages and disadvantages of the proposal and its potential impact on the delivery of veterans' health care.

Ideally, I believe the goal of the Medical Care Cost Recovery program -- the collection of payments from insurance companies -- is to help insurance companies meet their obligation and to provide the VA with additional sources of income, thereby improving its ability to deliver to veterans quality health care. If a VA medical center were able to utilize the funds it collects for direct health services to veterans, the program would appear to be beneficial to veterans. In its current form, however, we cannot be assured that individual medical centers would be able to channel collected funds in this way.

It also is important to ensure that other VA programs are not diluted in order to provide the resourses necessary to collect payments. Through its creation of the Third Party Medical Recoveries Fund, HR 4935 would address this potential problem and ensure that the program is sufficiently funded.

Mr. Chairman, I look forward to hearing from our witnesses and appreciate their efforts in preparing to testify before us today.

OPENING STATEMENT
CONGRESSMAN MIKE PARKER
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
HEARING ON THIRD PARTY REIMBURSEMENT

Thank you Mr. Chairman:
I want to express my appreciation to the various organizations and field officers of the Veterans Adminstration for appearing here today.

The Veterans Health-Care Amendments of 1986 require the Department of Veterans Affairs to collect a fee, commonly referred to as a Copayment, from certain Veterans who receive health care at its facilities. These requirements apply to any Veteran who has income or assets above prescribed amounts, unless he or she has a service-connected disability or other special circumstances.

The VA'S medical care cost recovery program must be reviewed and administrated with sound business principles. According to a GAO report published in March of 1990 on VA Health Care, out of five VA health centers visited only about half of the copayments that Veterans owed were collected. This occurred primarily because the centers failed to bill these Veterans. Some Veterans, however, did not pay when billed. No business can operate if it fails to bill its customers and fails to collect payments from its customers.

While it is important that our Veterans recieve fair and just treatment, it is also fair that we impose good business principles to insure the future for our Nation's Veterans.
Thank you Mr. Chairman

Harley O. Staggers, Jr.

Member of Congress

MR. CHAIRMAN:

LET ME COMMEND YOU AND THIS SUBCOMMITTEE FOR TAKING TIME TO HOLD THIS HEARING ON THIRD-PARTY REIMBURSEMENTS IN THE DEPARTMENT OF VETERANS AFFAIRS HOSPITAL SYSTEM. ALTHOUGH I WAS AN OPPONENT OF THE ESTABLISHMENT OF THE "MEANS TEST" FOR VETERANS, IT IS HERE AND HERE TO STAY. AS A RESULT IT SEEMS INCUMBENT UPON OUR COMMITTEE TO GET THE BEST ADVANTAGE FOR VETERANS WITH THE MONEY COLLECTED WITH THIRD-PARTY REIMBURSEMENTS.

I AM PLEASED THAT THIS SUBCOMMITTEE HAS TAKEN THE TIME TO HIGHLIGHT THE NEED FOR THE CONGRESS AND THE ADMINISTRATION TO TAKE A SERIOUS LOOK AT THIS MATTER. CLEARLY EVERY MEMBER OF THE HOUSE VTERANS AFFAIRS COMMITTEE KNOWS THAT THERE IS A CLEAR AND COMPELLING NEED TO GET THE BEST UTILIZATION OF EVERY DOLLAR THE DEPARTMENT OF VETERANS' AFFAIRS CAN GET ITS HANDS ON.

THE COLLECTION OF THIRD-PARTY REIMBURSEMENT IS CURRENTLY REQUIRED; HOWEVER, AT THE PRESENT TIME THE COLLECTION EFFORTS ARE LITTLE MORE THAN A DRAIN ON THE DVA. ALTHOUGH MONEY IS COLLECTED, IT HAS NO BENEFIT FOR THE VETERANS, - MANY WHO GLADLY PAY BECAUSE THEY WANT THE DVA TO SERVE MORE VETERANS- OR FOR THE HOSPITAL ADMINISTRATION THAT FINDS ITSELF COMMITTING VITAL EMPLOYEES AND RESOURCES TO THE COLLECTION EFFORTS, IN LIEU OF SERVING PATIENTS.

LAST YEAR I APPREARED BEFORE THIS SUBCOMMITTEE AND URGED THAT OUR COMMITTEE MOVE FORWARD AND YOU RESPONDED AFFIRMATIVELY. AS WITH MOST VETERANS ISSUES THE HOUSE COMMITTEE TOOK AFFRIMATIVE LEADERSHIP UNDER OUR ABLE CHAIRMAN AND PUSHED LEGISLATION THAT WOULD HELP VETERANS WITH THE INCREASED COLLECTION EFFORTS AND RESULTING BENEFITS TO OUR VETERANS.

LET ME TELL YOU OF MY PLEASURE THAT THE SUBCOMMITTEE HAS AS ONE OF ITS WITNESSES MS. JEAN BROWN, CHIEF OF THE INSURANCE AND FEE SERVICE BILLING UNIT AT THE VA MEDICAL CENTER IN MARTINSBURG. AS THIS SUBCOMMITTEE ALREADY KNOWS MARTINSBURG IS ONE OF THE MOST WONDERFUL PLACES ON THE EARTH. IT ALSO HAPPENS TO HAVE ME AS ITS REPRESENTATIVE IN CONGRESS. IT HAS CONSISTENTLY BEEN AT OR NEAR THE TOP COLLECTING UNIT IN THE COUNRTY. I AM SURE MS. BROWN'S TESTIMONY WILL BE VERY HELPFUL AS WELL AS THE OTHER WITNESSES HERE TODAY.

AGAIN, LET ME THANK THE SUBCOMMITTEE FOR ALLOWING ME A FEW MINUTES TO WEIGH IN SUPPORTING OUR EFFORTS TO COLLECT SO THAT WE CAN MAY SERVE LITERALLY THOUSANDS OF ADDITIONAL VETERANS.

United States General Accounting Office

GAO Testimony

For Release
on Delivery
Expected at
9:00 a.m. EDT
Wednesday,
June 20, 1990

VA Health Care Cost Recoveries

Statement of
Edward A. Densmore, Director
Planning and Reporting
Human Resources Division

Before the
Subcommittee on Hospitals and
Health Care
Committee on Veterans' Affairs
House of Representatives

SUMMARY

GAO recently issued two reports on VA's efforts to implement the medical care cost recovery provisions of the Veterans' Health-Care Amendments of 1986. These provisions involve (1) collecting from insurers for the cost of health care provided to veterans without service-connected disabilities, and (2) collecting fees, generally referred to as copayments, from certain veterans who have income or assets above prescribed amounts.

GAO found that VA's collections exceeded its recovery costs. However, VA had the potential to collect substantially more than it did, perhaps another $223 million. Ineffective procedures and a reluctance to spend the resources needed to maximize recoveries contributed to missed collection opportunities.

GAO recommended that VA take a number of steps to maximize its health care cost recoveries from insurers and veterans. VA's top management responded quickly to GAO's recommendations by (1) developing a comprehensive plan to improve its recovery procedures and (2) proposing legislation to improve the financing of its insurance recovery efforts. GAO believes that, after a slow start, VA is now on the right road to realizing more fully its health care cost recovery potential.

Mr. Chairman and Members of the Subcommittee:

I am pleased to be here today to discuss the Department of Veterans Affairs' (VA) health care cost recoveries. As part of the Veterans' Health-Care Amendments of 1986, the Congress included two provisions to help reduce the federal budget deficit. First, the Congress authorized VA to collect from insurers for health care provided to veterans without service-connected disabilities. Second, the Congress required VA to collect fees, commonly known as copayments, from veterans who have income or assets above prescribed amounts, unless these veterans have service-connected disabilities or meet other specified conditions.

As you know, we recently issued two reports to Senator Murkowski discussing VA's efforts to implement the 1986 amendments.[1] These reports summarized the results of our work at six VA medical centers and our analysis of responses to a questionnaire that all 159 medical centers completed. Our work at the six centers included reviewing records of randomly selected veterans who received care during a 6-month period in fiscal year 1988.

Our work showed that VA's collections exceeded its collection costs and, thereby, helped to slow the growth in the federal budget deficit. For example, VA medical centers collected about $100 million in fiscal year 1988 from health insurers at a cost of $8 million. However, the centers could have collected substantially more--perhaps an additional $223 million. VA's collections of copayments also exceeded costs in that year--about $10 million collected at a cost of $7 million. As with insurance recoveries, centers' collections should have been significantly higher than they were.

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[1] VA Health Care: Better Procedures Needed to Maximize Collections From Health Insurers (GAO/HRD-90-64, Apr. 6, 1990) and VA Health Care: Medical Centers Need to Improve Collection of Veterans' Copayments (GAO/HRD-90-77, Mar. 28, 1990).

The cost recovery performance of the 159 centers varied widely. Ineffective procedures at most centers and a reluctance to use the resources needed to maximize recoveries contributed to missed collection opportunities. The centers struggled, in large part, because VA's top management delegated recovery responsibility to them, but failed to provide the direction and tools needed to get the job done right.

Given the substantial benefit to the government, we concluded that VA's top management should take a more active role in helping medical centers maximize collections from health insurers and veterans. To do this, we recommended that the Secretary of Veterans Affairs ensure that each medical center

-- develop effective procedures for identifying insured veterans and billing the insurers for all inpatient and outpatient care provided to these veterans,

-- develop better procedures for billing and collecting copayments from veterans, and

-- has sufficient resources to fully implement the insurance procedures.

The Secretary responded quickly to address these recommendations by (1) listing the recovery processes as material weaknesses in VA's Federal Managers' Financial Integrity Act report for fiscal year 1989, (2) establishing a top-level management team to develop a comprehensive plan for improving VA's recovery procedures, and (3) developing a legislative proposal to finance the insurance recovery efforts. We have met with VA's team and are encouraged with the progress it has made in developing a comprehensive improvement plan. In addition, we believe that the Secretary's legislative proposal offers a viable approach to providing centers with the resources needed to maximize their insurance recoveries.

Now, I would like to discuss the major problem areas in VA's recovery processes, as well as actions VA is taking to overcome them.

BETTER PROCEDURES NEEDED TO MAXIMIZE INSURANCE RECOVERIES

The centers we visited frequently failed to collect from insurers because they did not identify all veterans who had insurance. For example, we conducted a test of the centers' admission practices and found that they had missed at least 1 out of 7 insured veterans who received inpatient care. Center officials offered several explanations for missing insured veterans. These included (1) clerks failing to ask the right questions during routine admissions interviews or (2) veterans being confused or afraid that disclosures about insurance would jeopardize their admission to the centers. The centers could have identified these veterans if their procedures had included steps to verify the information veterans provided, such as reviewing administrative and medical records. Nationwide, about two-thirds of VA's medical centers reported to us that they did not verify veterans' statements about insurance coverage.

Even when the centers identified insured veterans, they did not always bill insurers. For example, the centers we visited failed to bill more than 30 percent of the potentially collectible costs. Centers missed billing opportunities because they relied on flawed manual systems to develop the necessary data to prepare the bills. Billing staffs were not notified that insured veterans were discharged, and internal controls were inadequate to detect the missed billings.

In addition, the centers rarely processed bills promptly, resulting in additional lost revenues to the government. For example, only one of the centers we visited billed insurers within 30 days of providing inpatient care. Center officials said that

billing staff sometimes had to wait for several weeks to several months for doctors to prepare medical discharge summaries, which billing staff need so that they can prepare insurance bills.

To overcome these problems, VA's new implementation plan has identified specific tasks needed to strengthen its medical care cost recovery processes. One such task is development of specific policies and procedures for identifying insured veterans and billing insurers. These revised policies and procedures will be incorporated into a comprehensive guidebook. Another task is to emphasize training for those employees with responsibilities for identifying insured veterans and for billing insurers.

VA's plan also includes a project to identify insured veterans who were provided care since January 1989, but whose insurance companies were not billed. VA estimates that it can recover over $200 million if this project is successful. It is important to understand that for the project to capture recoveries for care provided in 1989, VA must send the bills before the end of calendar year 1990. This is because insurance policies generally contain provisions restricting the time within which providers may submit bills for payment.

BETTER PROCEDURES NEEDED TO MAXIMIZE COPAYMENT COLLECTIONS

The centers we visited collected only about half of the copayments that veterans owed. This occurred primarily because the centers failed to bill these veterans. As with insurance recoveries, weaknesses in procedures contributed to these missed billings. Most noticeably, billing clerks were not being notified when veterans owed copayments.

Some veterans, however, did not pay when billed. Several reasons were cited for the unpaid bills, including (1) veterans could not be located; (2) they refused to pay; or (3) they stated

that they could not afford to pay. Nationwide, about two-thirds of VA's medical centers reported to us that they often encountered such problems.

The centers' delays in sending bills appears to have also contributed to veterans' nonpayment. For example, the centers we visited usually sent bills several weeks to several months after care was provided. Overall, the centers sent three of every four inpatient bills more than 30 days after the veterans were discharged; the centers reported that no veterans paid before they left the centers.

We recommended that VA adopt an approach used in many private hospitals; that is, collecting from, or making payment arrangements with, patients before they leave the center. This would reduce VA's recovery costs as well as help to overcome many of the collection difficulties, such as the inability to locate obligated veterans. VA's top management team has completed its review of copayment billing delays and is considering several ways to increase copayment billing recoveries, including collecting from veterans before they leave the medical centers.

ADDITIONAL RESOURCES NEEDED TO
IMPROVE RECOVERIES FROM INSURERS

Most medical centers did not commit the resources needed to recover costs from insurers. Currently, VA medical centers must use medical care funds to finance recovery efforts and return all amounts collected to the U.S. Treasury. As a result, center officials face a difficult choice: use limited resources to increase recovery efforts or use them to provide medical care to veterans. Nationwide, about two-thirds of the centers reported to us that the number of available staff was less than adequate to effectively recover costs from insurers. The situation is well described in the statement of one medical center director. He said

he would not increase the center's financial commitment to the recovery effort until he received additional resources.

In April 1990, VA proposed legislation to establish a special fund to pay for the necessary personnel and administrative costs of the insurance recovery effort. All collections would be deposited into this fund. VA will use the fund to cover its recovery costs up to a prescribed ceiling (currently proposed as $25 million) and return the remaining balance to the U.S. Treasury. This proposal would provide VA the flexibility to use a portion of its collections either to contract for services or utilize its own personnel. We believe that VA should actively pursue whichever alternative results in the lowest recovery costs and thereby allows the highest return to the Treasury.

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Mr. Chairman, as I indicated at the beginning of my statement, VA has the opportunity to significantly increase its health care cost recoveries. Although VA got off to a slow start, we are encouraged that it now appears to be on the right road to realize more fully its cost recovery potential. This progress would not have been possible, within such a short time, were it not for the leadership and commitment exhibited by VA's top management concerning this important issue.

This concludes my prepared statement. We will be pleased to answer your questions.

STATEMENT OF S. ANTHONY McCANN
ASSISTANT SECRETARY FOR FINANCE AND PLANNING
DEPARTMENT OF VETERANS' AFFAIRS
BEFORE THE
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
COMMITTEE ON VETERAN'S AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
JUNE 20, 1990

Mr. Chairman and Members of the Subcommittee:

I am pleased to be here today and welcome the opportunity to share with you our views on VA's Medical Care Cost Recovery (MCCR) program. We particularly appreciate your including on the agenda VA's MCCR legislative proposal which you introduced on behalf of the Administration.

In budget discussions last fall, the Department examined its progress in implementing the third party reimbursement provisions of Public Law 99-272, the Veterans' Health-Care Amendments of 1986. We concluded that under current authority we could recover almost $400 million in FY 1991 from third party insurers. We decided this program should be a Department-wide priority and would require a two-pronged strategy. First, we need to improve program management. Second, we need to provide additional resources to the medical centers and some type of funding mechanism to reimburse hospital managers for their administrative recovery costs. In recognition of the priority of this effort, the Secretary decided that, as Chief Financial Officer, I should spearhead the effort to put together an effective Medical Care Cost Recovery program nationwide. It is in that capacity that I appear before you today.

GAO Reports on Medical Care Cost Recovery

First, I would like to address issues raised in the two General Accounting Office (GAO) reports about which you have indicated an interest. The two reports are "Better Procedures Needed to Maximize Collections from Health Insurers," and "Medical Centers Need to Improve Collections of Veterans' Copayments." The reports were initiated over 2 years ago and represent analyses of VA collections of third party payments from insurers and Category C copayments from veterans. GAO noted the difficulty in identifying veterans with insurance, in billing those cases identified, and in recovering from insurers the cost of VA medical care. GAO also found a need for improved procedures for billing and collection of copayments from those veterans to whom the copayment requirement applies. To maximize collections from insurers, GAO recommended that VA improve its procedures, and that the Congress provide adequate resources, either through the budget process or by permitting VA to defray the cost of collections from amounts recovered.

VA Management Improvements in Medical Care Cost Recovery

VA is currently engaged in a major effort to establish more effective management of the MCCR program. This effort will result in an increase in the identification, billing, and collection functions at the medical centers.

Following the 1991 budget discussions, in December of 1989, the Veterans Health Services and Research Administration (VHS&RA) formed an MCCR Task Force to examine MCCR policies and practices. The Task Force submitted its report with recommendations in April 1990. With the cooperation of VHS&RA, I then established a Joint Development Group comprised of staff

from VA Central Office, several top performing medical centers (some of whom are here today), and General Counsel. This group has been analyzing the MCCR Task Force recommendations, the recently released GAO reports, other VA reports on MCCR, and has made its own recommendations on the MCCR program. On June 1, 1990, the group completed an Implementation Plan which establishes the tasks that should be accomplished, with time frames for the accomplishment of each of the tasks, the actions and resources required, and the persons responsible for carrying out the tasks. The implementation of this plan will significantly enhance the MCCR program and address, in essence, all of the recommendations in the two GAO reports.

Some key tasks included in the plan are the development of an integrated, easy to use, "how to" manual detailing all aspects of the MCCR program; establishment of a local MCCR coordinator and organization; a comprehensive and continuing training program; several changes in automation to increase efficiency; improvements in educating veterans about the importance of their cooperation; and establishment of more effective working relationships with insurers.

The main thrust of our legislative proposal and the improvements in program management I have outlined is to effectively implement the 1986 law. I will now discuss the specific proposals in H.R. 4935.

VA Legislative Proposal

Mr. Chairman, on April 19, 1990, you introduced, by request, H.R. 4935, an Administration proposal to expand and enhance the Department's MCCR program.

Section 2 of the bill would permit VA to recover from health insurers the cost of care furnished to a service-connected veteran for treatment of a nonservice-connected disability. Current law limits recoveries to health plan contracts of veterans with no service-connected disabilities.

Under the provisions of 38 U.S.C. § 629, the United States may recover from crime victims' programs, automobile reparations insurance, workers compensation laws, and health insurance plans, the cost of medical care furnished by the Department of Veterans Affairs. Except with respect to health insurance, recoveries may be had from each of these sources, as well as from tort feasors pursuant to the Federal Medical Care Recovery Act, 42 U.S.C. §§ 2651-2653, for the reasonable cost of care furnished for a nonservice-connected disability, whether or not the veteran also has a service-connected disability. In the case of health insurance, however, recovery may be had only from insurance of veterans with no service-connected disabilities. The bill would, therefore, make VA's third party Medical Care Cost Recovery program more consistent.

Enactment of Section 2 of the proposal would result in increased recoveries estimated at $111,570,000 in the first year and $597,033,000 over the first 5 years.

Section 3 of the bill would clarify the amount of an insurer's liability to VA for the reasonable cost of care furnished for a nonservice-connected disability. Some insurers have insisted on discounting VA's medical care charges without reference to the cost of similar care in the community. As currently drafted, the statute permits the insurer to make payments for care based upon reasonable cost as determined by the Secretary or in accordance with "the prevailing rates at which the third party makes payments under comparable health-plan contracts"

with non-Federal facilities in the geographic area. The intent of this provision was to permit the insurer to pay the usual and customary cost of care rather than the VA determined charge when, for example, the cost in the particular medical community was lower than the VA charges. The amendment would clearly indicate the insurer's option to pay either the VA determined charges or the amount usually and customarily paid for similar medical services in the community. This provision is in the nature of a technical amendment and is not expected to have a significant impact on recoveries.

Section 4 would create a Third Party Medical Recoveries Fund ("the Fund"), to be separate and apart from the Medical Care Account. Amounts collected from third parties would be deposited in the Fund. The costs of identification, billing, and collecting, currently funded from the Medical Care Appropriation, would be defrayed instead out of the collections deposited in the Fund, whether such costs were incurred in the use of VA or a contractor's services. Annually, the excess of collections over the lesser of the amount appropriated to or obligated by the Fund would be deposited in the Treasury as miscellaneous receipts.

This new account is a critical element of our plan to revitalize the MCCR program. It is designed to resolve the current dilemma of trading off medical care resources to fund third party activities, since VA's cost of billing and collection must now come from the Medical Care Account. The amendment will provide VA the flexibility to choose to contract for services or utilize its own personnel, whichever is more efficient.

The Fund would be initially staffed and funded with up to 500 FTEE and $18.6 million transferred from the Medical Care

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Account, representing resources currently devoted to third party medical care cost recovery. In addition, the President's Budget has requested that an additional 300 FTEE be added to the program in Fiscal Year 1991. These additional resources are expected to cost $6.4 million, and would be defrayed from collections deposited into the Fund.

In its recent report, "Better Procedures Needed to Maximize Collections from Health Insurers," the General Accounting Office recognized the potential for far greater recoveries. GAO recommended not only stronger management actions, a recommendation with which we concur and have taken steps to implement, but also legislative authority to defray costs of collection from amounts recovered from health insurers. The Fund and the associated resources to be devoted to the program through the mechanism of the Fund, are essential to our objective of maximizing recoveries.

We estimate that enactment of Section 4 of the bill, establishing the Fund, together with approval of the President's Budget request for additional resources, would result in increased recoveries in the first year of $254 million, and $2.3 billion over the first 5 years, with first-year and 5-year increased costs of $6.4 million and $34.2 million, respectively.

Another provision of the bill, Section 5, would clarify VA's authority to collect from Medicare supplemental (medigap) insurance policies. Section 629 excludes from the definition of "health-plan contract" the Medicare and Medicaid programs, and VA, therefore, does not submit bills to either program. While many medigap insurers reimburse VA, a number of insurers have taken the position that, because VA may not collect from Medicare, there is no liability on medigap policies. In its recent report, the General Accounting Office agreed with the VA

position. The amendment will make it clear that such policies are, indeed, liable to reimburse VA as if the care had been furnished by a private Medicare provider.

Mr. Chairman, VA is currently engaged in a major effort to establish more effective management of the Medical Care Cost Recovery program. While this effort should result in an increase in identification, billing and collections, it is predicated on the establishment of the Fund proposed in this legislation and the additional resources to be allocated specifically to the program. This proposal provides the mechanism, through the Fund, to reimburse the administrative recovery effort with collections and to give medical center directors an opportunity to staff this function without having to make a choice between collecting from health insurance and providing care to our Nation's veterans.

Mr. Chairman, this concludes my testimony, and I would be pleased to respond to any questions that you or any member of the Subcommittee may have.

DEPARTMENT OF VETERANS AFFAIRS
VETERANS HEALTH SERVICES AND RESEARCH ADMINISTRATION

MEDICAL CARE COST RECOVERY TASK FORCE FINAL REPORT

APRIL 30, 1990

EXECUTIVE SUMMARY

FINAL REPORT
MEDICAL CARE COST RECOVERY (MCCR) TASK FORCE
April 30, 1990

On November 22, 1989 the Associate Deputy Chief Medical Director (10B) established the MCCR Task Force. Its charge was to assess the policies, procedures, automation support, and staffing which VHS&RA currently devotes to medical care cost recovery. By April 30, 1990, a plan of action was due which would insure collection targets are met.

The goal of $304 million set by VHS&RA for FY90 is unlikely to be achieved. Even the more conservative goal set by OMB of $141 million is unlikely to be reached unless immediate action is taken on some recommendations contained in the Task Force report. The reasons for this are several and are identified throughout the report. Poor incentives and failure to adequately fund this start-up program at a time when direct care programs were being reduced are the major reasons.

The recommendations with the greatest potential for influencing FY90 collections are those relating to incentives, commercial billing and collection services, and assist teams.

The Task Force views with skepticism all estimates made to date of potential collections. No data base currently exists from which accurate estimates can be made. Extrapolating from a few, sometimes non-randomly selected medical centers does not produce defensible estimates.

This final report contains 41 recommendations for improving collections. If approved, they can provide a means for more accurate estimates of collections, improve program oversight, and enhance DVA's ability to identify and collect billable cases which do exist. Among the more significant recommendations are:

o Earmark $2 million in FY90 for individual and organizational incentive programs to reward exceptional performance and innovative program ideas.

o Regarding the FY91 budget initiative to setup a separate appropriation for billing and collection, the initial 'seeding' of 500 FTEE should be borne by medical care and other appropriations supporting MCCR activities. The additional 300 FTEE should predominately be distributed to the field based on performance with a small number reserved for other program elements.

o Improve the data base for patient accounts to include modification in CALM and PTF/OPC files. There is insufficient information at the present time upon which informed estimates and policy decisions can be made in the MCCR program.

o Pilot the use of commercial billing and collection services for unbilled cases, doubtful accounts, and full service programs.

o Establish 'assist teams' which could travel to VAMCs who are having problems with billing and collection and help them improve their programs.

o Improve the timeliness and accuracy of billing rates. More than a 21 percent gain in collections can be realized by improving rate computations. The use of alternative rate methodologies needs testing to include case-mix, locality-based, and/or patient-specific billing.

o Appoint Billing and Collection Coordinators at each VAMC who will be responsible for coordinating training, policies, procedures, and other elements of the program.

o Create a follow-on organization to the Task Force composed of a multi-disciplinary

field and VACO team. In addition, create a subgroup to this committee to develop specifications and oversee an improved receivable revenue software package.

o Improve techniques and oversight relating to the speed with which collections are made.

o Carefully monitor the impact on access to care if incentives are offered for caring for veterans with health insurance. Study the affect on veteran health insurance rates of MCCR policies.

Respectfully submitted on behalf of the MCCR Task Force members.

John C. Powers
Chairman

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SUMMARY OF RECOMMENDATIONS

Many of the recommendations made by the Task Force are conceptual and will require further development if approved. Some recommendations may contain elements with which policy makers disagree, but otherwise have merit. To gain a sense of top management's support for the recommendations, the decision line has been modified from the normal 'approve/disapprove' to include two other categories. The choices presented are as follows:

Action	Definition
Approved	Recommendation approved without reservation. Proceed with implementation plans.
Concept	Conceptually approved. Final approval will be considered when details, as noted, are developed.
Rework	Recommendation has merit, but some aspects are troublesome (as noted). Resubmit for approval after modifications are made.
Disapproved	Disapproved for reasons cited.

Many of the recommendations will require coordinated action by more than one VACO program element. The Task Force suggests assigning follow-up responsibility to the VHS&RA MCCR Coordinator. An asterisk * is shown above the recommended choice of the RD's (re: 10BA6 ltr of 3/9/90) except for new items.

INCENTIVES

Recommendation #1 - Award criteria for individual and institutional awards should be measurable to the extent possible and developed in cooperation with VHS&RA field operations. Selections should require the concurrence of the Regional and/or Medical Center Directors. Supporting funds should be centrally funded from medical care in FY90 and, if legislation permits, collections in FY91 and after. If legislation does not permit, support from medical care should be continued.

*

Approve/Concept/Rework/Disapproved

Recommendation #2 - Request the Assistant Secretary for Finance and Planning to initiate an annual awards program for excellence in VA financial management. Categories should include, but may not be limited to excellence in billing and collection activities. These activities range from admissions screening to cashiering. Personnel involved in supporting functions such as IRM should also be eligible. Nominations should be entirely restricted to field personnel. Limits on repeat awards should be imposed. Awards for the top 10 individuals should be presented at an annual ceremony held in Washington, DC. The travel of recipients' spouses should be funded (CG B-233607) to enhance the award ceremony. Awards should include a combination of plaques, certificates, autographed photos, and $1,000 each as discussed in the body of the report.

*

Approve/Concept/Rework/Disapproved

Recommendation #3 - Establish semi-annual CMD awards for outstanding performance in the area of billing and/or collection. Eligibility for awards should include recognition of top management as well as individual employees involved at the VAMC. Selections should be made by Regional Directors based on nominations from Medical Center Directors. Recipients would be among those considered for annual Assistant Secretary awards. Criteria should be quantitative to the extent possible using the factors identi-

fied above and should be consistent across Regions.

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Approve/Concept/Rework/Disapproved

Recommendation #4 - VHS&RA should sponsor a competitive, internal RFP annually to encourage innovative changes which can improve the billing and collection functions. This should include at least partial funding support or, if possible, full funding by offsetting collections. Priority should be given to funding projects which involve multi-facility cooperative efforts. The MCCR Task Force successor group could judge proposals and recommend selections to 10B, the CMD, and/or Assistant Secretary for Budget and Finance. A total of $1,000,000 should be earmarked for these proposals.

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Approve/Concept/Rework/Disapproved

Recommendation #5 - Performance standards for managers as well as employees should account for MCCR program performance. Facility Directors should be encouraged to establish local awards programs for billing and collection activities. A designee from Management Support should be appointed to work with the Task Force successor organization to develop detailed policies and procedures which will encourage these programs within VHS&RA.

•

Approve/Concept/Rework/Disapproved

COST OF COLLECTION

Recommendation #6 - If the FY91 budget proposal is approved, assign a portion of the NTE 500 FTEE 'seeding' to MAMOE and GOE as well as Medical Care. Insure new positions are established for each of the additional 300 FTEE appropriated. Reserve a small portion of the new FTEE for VACO and non-field use. Distribute the remainder to VHSRA field activities using a combination criteria of proration and performance as described in the body of the report. Monitor those charging expenses to the new appropriation to ensure a balance is maintained between the original 'seeding' and subsequent period charges.

•

Approve/Concept/Rework/Disapproved

Recommendation #7 - VA should be wary of relying on estimates made to date for total collections and cost per dollar collected. Further, any national budget reconciliation which relies on them should make known this caveat. Supporting papers from which cost of collection estimates were created should be examined by knowledgeable experts. Comparisons on cost per dollar collected should be made with private health care sector activities.

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Approve/Concept/Rework/Disapproved

Recommendation #8 - Set-aside $180,000 (of the $2 million earmarked) to pilot the use of commercial billing and collection services at one or more medical centers the second half of FY90. This would allow for commercial billing approximately 10,000 patient billings. The services should include unbilled cases, doubtful accounts, and full billing and collection services. The cost versus benefits of using commercial versus in-house services should be carefully evaluated by an objective study group.

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Approve/Concept/Rework/Disapproved

Recommendation #9 - Among the innovative pilot programs funded through national competition (re: Recommendation #4), include one or more multi-facility cooperative programs especially in New York, Los Angeles, Chicago or other major urban center.

The Task Force or its successor should investigate the services offered by commercial cooperatives and, if warranted, pilot their use. Assign some group or outside contractor the responsibility of completing a thorough review of VA's billing and collection apparatus.

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Approve/Concept/Rework/Disapproved

Recommendation #10 - Redefine CDR account 6016 to include the cost of billing and collecting 1st party medical copayments and deductibles. Allow 200, 600, and 700 series cost centers as well as 400 series cost centers to be charged to this CDR account.

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Approve/Concept/Rework/Disapproved

TRAINING

Recommendation #11 - VHS&RA should endorse and support with resources as necessary the following training and education activities for MCCR.

- o RMEC sponsored education including 'how to' manuals
- o E-mail groups and newsletters
- o Canned education programs
- o Top management education programs
- o Annual meetings of selected billing and collection personnel
- o Reference/assist teams
- o Private sector educational assistance
- o Monthly conference calls
- o Self-evaluation checklists (SCEMS)

The support should include a willingness to commit medical care resources if legislative authority to offset collections is not granted. The Task Force or its successor organization should work with appropriate VACO officials to more fully develop implementation policies and procedures.

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Approve/Concept/Rework/Disapproved

BILLING IDENTIFICATION

Recommendation #12 - Designees from Learning Resources and Public Affairs should be designated to work with the Task Force's successor to continue the development of patient and VSO education material which will help them better understand and cooperate in the MCCR effort.

Approve/Concept/Rework/Disapproved

Recommendation #13 - Training activities need to emphasize the importance of identifying billable cases prior to the patient completing the episode of care. Facilities should also be encouraged to establish participating providor agreements and work more closely with local payors. Commercial verification programs should be also used where the cost is likely to be recovered such as for facilities with low billings, yet numerous high cost inpatient NSC treatments.

Approve/Concept/Rework/Disapproved

Recommendation #14 - The Chief Medical Director should charge MIRMO and MAS with the responsibility for developing and accelerating the introduction of an improved scheduling, registration, and tracking system for non-acute bed care workload. Among

need to request OMB approval for new rates. If this is not possible, a firm schedule should be agreed upon among involved parties including OMB to ensure new rates are published by September 1st each year.

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Approve/Concept/Rework/Disapproved

Recommendation #20 - Improvements are needed in rate setting computations to include more expenses in the 'all inclusive' rate. Among the suggestions offered by the Task Force are:

a. VHS&RA Resource Management Office should establish a separate CDR account for 'big ticket' prosthetics appliances costing $500 or more. These items should continue to be billed on an actual cost basis. Other prosthetic costs including salaries, repairs, and small appliances should be re-bundled as part of the all inclusive per diem or visit rate. The importance of this recommendation will increase if billing for SC veterans treated for NSC conditions is legislated.

b. For billing 'big ticket' prosthetic appliances and non-VA care services, rate setting officials should develop an overhead factor to be added to actual cost by facility personnel to account for indirect support provided by facility, VHS&RA, Department, or other Government units.

c. Rate setting officials should develop billing rates for home health care and other off-site medical care delivery by VA staff whose expenses are not now included. This will require cost and workload data to be gathered by billable units.

d. A comprehensive review of expenses distributed to the 6000 series of CDR accounts should be completed. All costs which support the delivery of care including District/Regional support, continuing education, beneficiary travel, and others should be included in the rate structure on a prorata basis similiar to other indirect costs.

Note: If all of the above recommendations were approved, billings could potentially increase an average of 21 percent.

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Approve/Concept/Rework/Disapproved

Recommendation #21 - The Assistant Secretary for Finance and Planning should modify transitional adjustments which bridge past, current and budget fiscal years to include adjustments for workload trends as well as cost. This will improve the accuracy of the workload units, i.e. patient days or visits, used in the denominator of the rate computation. VHS&RA should assist *in* this effort by budgeting workload in units which correspond to the billing rate structure. These should be coordinated with OMB if necessary.

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Approve/Concept/Rework/Disapproved

Recommendation #22 - MAS and Resource Management should be tasked with reviewing patient day data in the CDR and MCCR package to determine if absent bed occupancy and pass days have been excluded. If not, they should be removed when computing rates and preparing billings to make them internally consistent.

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Approve/Concept/Rework/Disapproved

the improvements, there should be a better means for identifying patients, identifying services performed to include diagnostic and procedure codes, and handing data off to an improved billing and collection system. The new system should provide for hardware and software which can use labor saving technology such as the outpatient cd-rom card under study at the Troy ISC.

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Approve/Concept/Rework/Disapproved

MANAGEMENT INFORMATION

Recommendation #15 - A number of enhancements should be made to DHCP and central systems to support improved data tracking and reporting as well as more sophisticated patient accounts management. An Applications Requirements Group (ARG) should be formed within 30 days to identify short-term requirements. Among the requirements to be addressed are those mentioned in paragraph VIII (A - E) located in the body of the report. MIRMO and/or managers of central systems should then identify resource needs to fast-track delivery of necessary products. The features, cost, and delivery schedule of commercial software should be examined by the ARG as they consider development options. The program costs should be offset against collections if this authority arises.

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Approve/Concept/Rework/Disapproved

Recommendation #16 - The FY91 budget proposal should be amended to provide billing authority if the 'dominant' portion of an episode of care is related to a NSC illness or injury. As the VA's patient accounting system matures, consideration should again be given to charging only for tests, procedures, clinics, and days of care associated with NSC conditions.

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Approve/Concept/Rework/Disapproved

FINANCIAL ACCOUNTING

Recommendation #17 - To improve the functionality of the VA general ledger account structure, the Task Force recommends the Deputy Assistant Secretary for Financial Management (047) expand the use of general ledger modifier codes. The new codes would be used for identifying the class of adjustment or denial code. Further, a modifier code or separate general ledger account should be established to estimate differences between gross receivables and collections due because of insurance coverage limits. The Task Force recognizes the difficulty in changing the current COBOL-based financial software. This notwithstanding, we believe this change is necessary to avoid overstating receivables and provide needed management information.

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Approve/Concept/Rework/Disapproved

Recommendation #18 - The Deputy Assistant Secretary for Financial Management (047) should establish subsidiary accounts for general ledger account 2236 and/or 4018 to differentiate, at a minimum, the allowance for doubtful accounts estimated for current and past year medical care appropriations and general fund receivables associated with MCCR collection, e.g. ineligibles, means test, etc. One method for doing this would be adding suffixes, e.g. .01, .02, etc. much the same as those used with GL account 1221.

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Approve/Concept/Rework/Disapproved

RATE SETTING POLICY

Recommendation #19 - The Assistant Secretary for Finance and Planning should request authority to disengage VA rate setting from other Federal hospitals and eliminate the

Recommendation #23 - Rate setting staff should confer with Resource Management to determine which additional intra-VA costs should be included in the medical care rates. At a minimum, a prorata portion of GOE should be included.

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Approve/Concept/Rework/Disapproved

Recommendation #24 - Rate setting officials should be requested to clarify adjustments for capital interest which are now applied to operating expenses. If appropriate, they should apply them only to the unamortized portion of plant and equipment costs as suggested in this report. Since most Government real property has been owned for many years, it is unlikely current borrowing costs are significant except for movable equipment.

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Approve/Concept/Rework/Disapproved

Recommendation #25 - Rate setting officials should include an allowance for tort claims paid on behalf of medical care and charged to the open treasury appropriation established for that purpose.

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Approve/Concept/Rework/Disapproved

Recommendation #26 - The Boston Development Center, DMMS Project Team, and Region 1's Management Science Center have all been involved with different aspects of this issue. They have the combined expertise to investigate the benefits of alternative rate methodologies. The Task Force recommends a subgroup be designated composed of representatives from these organizations and Budget Service to evaluate the costs versus benefits of adopting an alternative rate methodology.

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Approve/Concept/Rework/Disapproved

ORGANIZATION

Recommendation #27 - Accelerate the introduction of DMMS. Consider piloting a detailed patient billing using DMMS facility-level charges. If collections can be improved by using the capability of DMMS, consider underwriting part of its cost with MCCR collections.

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Approve/Concept/Rework/Disapproved

Recommendation #28 - Continue authority for local facility Directors to internally organize billing and collection functions as the local situation dictates. Encourage realignment of functions or duties into a centralized unit where effective.

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Approve/Concept/Rework/Disapproved

Recommendation #29 - Require medical centers to designate a MCCR Coordinator similar to RMEC and AMIS liaison Officials. Insure that Resource Management includes in the definition of CDR account 6016, Billing and Collection, costs for each of the above functions.

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Approve/Concept/Rework/Disapproved

Recommendation #30 - Appoint a VHS&RA Manager of MCCR Billing and Collection activities who would coordinate the efforts of the various VACO elements supporting the program. This manager would also serve as the contact point for field-based MCCR Coordinators.

Approve/Concept/Rework/Disapproved

Recommendation #31 - Orient the mission of the proposed financial quality assurance group towards 'assistance' rather than 'auditing'. The Task Force believes this will have a more positive impact on medical center financial operations.

Approve/Concept/Rework/Disapproved

Recommendation #32 - Commission a private consulting study to evaluate the appropriateness of the current functional alignment and position classification structure necessary to properly manage a patient accounts program estimated to grow to $1 billion in 5 years.

Approve/Concept/Rework/Disapproved

Recommendation #33 - Upon dissolution of the MCCR Task Force, appoint a permanent advisory group which would report to the VHR&RA MCCR Program Coordinator (see recommendation #28). The advisory group should have VACO and field representation from all major functional areas involved in the MCCR program. At a minimum, this should include representatives from QA, MAS, IRM, General Counsel and Finance.

Approve/Concept/Rework/Disapproved

CASH MANAGEMENT

Recommendation #34 - The VACO MCCR Billing and Collection Coordinator should develop statistics such as days in net accounts receivable comparable to private sector hospitals for monitoring the promptness with which payments are made. These statistics should, in part, form the basis of performance award criteria. Periodically, a survey should be conducted of randomly selected receivables to identify bottlenecks which may be occurring in billing, UR, accounting or other activity which processes AR's.

Approve/Concept/Rework/Disapproved

Recommendation #35 - VA should exercise whatever authority currently exists for selectively imposing interest penalties on unwilling and tardy payors. Should authority not exist, VA should consider introducing legislation which would impose an interest penalty or similar sanction on selective payors who repeatedly fail to pay properly submitted billings within 30 days of receipt.

Approve/Concept/Rework/Disapproved

Recommendation #36 - VAMCs should be encouraged to issue interim billings for long-stay patients every 30 days if a likelihood exists the patient will remain hospitalized for at least 30 more days after each interim billing period arrives.

Approve/Concept/Rework/Disapproved

Recommendation #37 - The VHS&RA MCCR Coordinator should ensure positive results of pilot activities on electronic billing are fully exploited. Other techniques such as the use of lock boxes, special handling of billable case records, decision rules on claims follow-up, and others are tested and encouraged where appropriate. Encourage VAMCs to use credit card devices in patient registration areas so deductibles and copayments can be collected prior to treatment for category B and C veterans.

Approve/Concept/Rework/Disapproved

MANAGED CARE PLANS

Recommendation #38 - VHS&RA should pilot a small number of managed care agreements to develop more expertise in this area. Pilots should include HMO and PPO agreements. These pilots could also determine if collections can be increased or accelerated through the use of managed care arrangements. VA should consider obtaining authority for two or three medical centers to negotiate prices locally as long as the marginal cost of additional caseload is covered. Initially, managed care agreements should be restricted to veteran patients.

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Approve/Concept/Rework/Disapproved

RESOURCE ALLOCATION FORMULAS

Recommendation #39 - Developers of resource allocation methodology should consider the financial impact likely to occur on third party reimbursements. If a new methodology is likely to decrease reimbursements, VHS&RA's collection target should be modified accordingly or the methodology should be adjusted to remove disincentives.

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Approve/Concept/Rework/Disapproved

IMPACT ON THE VETERAN

Recommendation #40 - Task an HSR&D or other qualified group to perform a multi-year study to determine if health insurance premiums for veterans subject to third party insurance reimbursements increase more or at the same rate as other veterans or the population as a whole especially for those working in small businesses. If cost-plus incentives are legislated, maintain a continuous monitor of indicators which would warn if adverse selection processes are being introduced.

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Approve/Concept/Rework/Disapproved

Recommendation #41 - The continued sharing of ideas and efforts between DOD and DVA in the medical care cost recovery program should be encouraged by regular meetings and allowing DOD representatives to participate in MCCR conference calls and e-mail groups. DOD and DVA should designate liaison persons who will be responsible for encouraging the sharing of ideas within the third party insurance program.

Approve/Concept/Rework/Disapproved

FINAL REPORT
MEDICAL CARE COST RECOVERY (MCCR) TASK FORCE
April 10, 1990

I. PURPOSE

The MCCR Task Force was authorized by the Associate Deputy Chief Medical Director (10B) on November 22, 1989. This is the final report recommending actions which are important in achieving FY90 and future year collection targets. Some items are presented in concept only and will require more follow-on work by a successor organization.

II. MEMBERSHIP

The membership of the Task Force consisted of the following DVA personnel:

Walter Besecker, Finance Service (047)
Dan Bishop, Director, Albany ISC (10B/IRM)
Doug Bradshaw, Deputy Asst. General Counsel (021B)
Dan Cameron, Chief Fiscal, VAMC Hines
Jack Grady, Health Systems Specialist (10BA5)
Cherly Hoffman, QA Coordinator, VAMC Oklahoma City (00A)
Terri Hopkins, Chief MAS, VAMC Gainsville (136)
Milt Jones, Chief Debt Collection, Loan Guaranty, and Insurance Division (047F3)
Jim Mashburn, San Francisco ISC
Ron Michaels, Chief Fiscal, VAMC Pittsburgh (UD) (04)
Alline Norman, Director, MAS (136)
Diane Parlow, District Counsel, Washington, D.C.
John Powers, HSS (10BA1) Chairman
John F. Scudieri, Associate Director, VAMC East Orange (001)
Tom Thomas, Chief Fiscal, VAMC Portland (04)
Paul Tryhus, MAS (136F)

III. BACKGROUND

A. PL 99-272 - Since 1986 when PL 99-272 extended VA authority to recover medical care costs, medical centers have struggled to begin a patient accounts program for which few resources were provided. About 1 FTEE per medical center was funded in FY 1987 primarily for means test workload. This funding was offset by 1% productivity cuts, absorption of health benefits expenses, absorption of within-grade increases, and underfunded inflation allowances.

Also, the resources provided did not account for the added expense of General and District Counsel, IRM development sites, ADP hardware, and other activities needed to establish a patient accounts management system.

A successful collections program combines the skills of many people in many disciplines including, but not limited to Medical Administration, Utilization Review, Fiscal, Information Resources, and District Counsel. Depending on the size of the collection program, MCCR-related duties may involve only parts of several employees' workdays making the apportionment of the funded FTEE a problem.

Few would agree that one FTEE per medical center is sufficient to meet the needs of PL 99-272. This lack of support will jeapordize VHS&RA's ability to meet FY90 collection targets. Devoting more FTEE than funded may not be possible without diverting them from direct

patient care.

B. Uniqueness of VA Program - Third party billing in DVA has two unique characteristics. First, veterans are not obligated to provide insurance information. If a veteran is otherwise eligible, care cannot be denied. This increases the importance of admission screening. Additionally, unlike private medical centers, DVA cannot bill the veteran for the cost of care not reimbursed by 3rd parties. This requires DVA billing personnel to be more familiar with 3rd party insurance plans so all payments due are collected.

The second unique aspect of the DVA collection effort is the lack of local financial incentives. Collections are deposited to the credit of the US Treasury rather than as reimbursements to the medical care appropriation. Even the marginal costs of billing and collection functions are not reimbursed. This has a dampening affect on the collections program. More than one proposal has been suggested for curing this problem. As will be pointed out later in this paper, competing proposals must be carefully examined to avoid commercializing DVA medical care.

The remainder of this report provides observations and recommendations on several functional areas which the Task Force was asked to address in the charge letter.

IV. INCENTIVES

A. Lack of Incentives - The most often heard complaint from medical centers regarding PL99-272 regards the lack of financial incentives. Collections are deposited as general fund receipts. Not even the cost of administering the program are recoverable by the DVA. Various proposals have been introduced to solve this problem. They range from reimbursing only the cost of billing and collection to cost-plus reimbursement if collection targets are exceeded.

There is substantial documentation in the Congressional Record of opposing viewpoints voiced by Veteran Service Organizations (VSOs) and Members of Congress. The Task Force wishes to add its thoughts to this debate.

B. What Should Be Done? - Members of the Task Force uniformly agree that at least the cost of MCCR program administration should be recoverable. This includes all marginal costs of the program ranging from admissions screening to cashiering; from developing software to training.

The Task Force does not unanimously favor cost-plus reimbursements. The dissenting viewpoint holds that such incentives may alter the nature of DVA care. VHS&RA's experience with RAM shows how quickly medical centers react to incentives which produce more local funding. If medical centers are allowed to earn more collections than are needed to cover program costs, a bias could develop favoring veterans who have insurance. This could commercialize DVA medical care and diminish its character as an earned benefit.

In FY90, the Department of Defense released instructions to their treatment facilities authorizing local retention of third party collections. DVA should closely monitor the effect this has on treatment and collection patterns so it can learn from the DOD experience.

The Task Force members believe incentives are needed to invigorate the billing and collection program. There is a risk, however, that too much attention could cause this program to overshadow other more important aspects of VHS&RA's mission including those related to direct patient care. The Regional Directors expressed concern about this matter in their response to the draft report.

This notwithstanding, the Task Force believes special attention is needed during the initial years of the third party collection program to bring it to a well functioning level. This is especially important considering the sudden increase in collection targets scheduled for FY91

and after.

C. FY90 Funding Source for Incentives - Members of the Task Force understand that $2 millon in medical care funding has been set-aside in FY90 to fund innovative projects related to billing and/or collection. Since no authority exists in FY90 to offset collections for incentive awards, project funding, etc., the Task Force believes these set-aside funds should be used for a variety of purposes.

We assume there will be new legislation in FY91 which will permit charges to be made to collections for at least the cost of program administration. This will provide a continued source of funding for actions the Task Force is recommending which are recurring in nature. Should this not be the case, the Task Force believes the incentives described below should continue to be supported by medical care funds thru FY92. At this point the incentives should be reevaluated in view of program performance and other VHS&RA objectives to determine if they should be discontinued or changed.

The Task Force believes the $2 million set-aside for FY90 should be earmarked in the following manner:

o $10,000 to fund 10 individual special achievement awards at $1,000 each to VHS&RA field personnel who have shown exceptional achievement in the area of billing and/or collection. These awards would be associated with annual Assistant Secretary for Finance and Planning recognition awards described later in this report. An additional amount of .007 travel would be needed to fund the travel of recipients and spouses to attend the award ceremony.

o $63,000 to fund 126 individual special achievement awards (18 per Region per year). Half would be awarded every six months for $500 each (total of 126 awards annually) in association with the semi-annual CMD awards described later.

o $180,000 to fund a pilot project to investigate the cost versus benefits of using a commercial billing and collection firm in lieu of in-house staff. Based on the current GSA contract, this would allow for approximately 10,000 accounts receivable to be handled commercially.

o $1,000,000 to fund innovative pilot programs as described elsewhere in the report. These funds would be competively awarded.

o $747,000 or the balance to be awarded to the top 10 facilities who achieved the best performance in billing and collection during FY90. As mentioned later, the precise method for measuring performance and apportioning the award money is to be determined. The funding award would be institutional rather than individual. Provisions should be made to fund equipment, ADP, or operating funds as the medical center desires. Award decisions and funding should be made by August 15, 1990 to permit adequate time to spend the money prior to the close of the fiscal year.

Each of these items is contained in separate recommendations described later in the report. The award categories and criteria should be announced as early in FY90 as possible. This will give them maximum opportunity to influence billing and collection behavior.

D. Award Criteria - Each of the proposed incentives will require some measureable criteria to determine award recipients. Among the measures which could be used to judge performance are:

(a) Amount collected
(b) Ratio of amount collected to amount billed
(c) Ratio of amount collected to FY goal

(d) Billing accuracy
(e) Timeliness of collections
(f) Other individual or group actions which led to significant improvements in billing and/or collection activities.

The exact combination and application of these measures would have to be developed and weighted for such things as the type of medical center, billing volume, and other significant factors.

The Task Force believes the exact criteria should be developed in cooperation with field personnel by distributing an issue paper to all VHS&RA field operations for comment. The criteria should be quantitative to the extent possible. Selections should require the concurrence of line supervisors including the Medical Center and Regional Directors.

Recommendation #1 - Award criteria for individual and institutional awards should be measurable to the extent possible and developed in cooperation with VHS&RA field operations. Selections should require the concurrence of the Regional and/or Medical Center Directors. Supporting funds should be centrally funded from medical care in FY90 and, if legislation permits, collections in FY91 and after. If legislation does not permit, support from medical care should be continued thru FY92 at which time they should undergo 'sunset' review.

E. Financial Management Annual Awards - The Department of Treasury sponsors annual awards in Financial Management. These awards are made to individuals or groups within the Executive Branch for specific achievements in the areas of collections, payments, and credit management. They are sponsored to encourage and recognize exemplary leadership and excellence in the collection or disbursement of Federal Government funds.

Generally, field-based employees in VHS&RA would not qualify for these awards because the scope of their work does not usually extend beyond the medical center. Yet, efforts of field-based VHS&RA employees determine the success of VA's third party collection program.

The Task Force believes the introduction of a similiar series of awards in VA for which only VHS&RA field personnel could be nominated would prove to be an important incentive. Individual and/or group awards could be presented annually for exemplary work in MCCR activities. Other financial management award categories could be added for excellence in cost accounting, resource management, financial automation, or other activities.

The awards will require VACO action to establish and may in some cases involve impact and implementation negotiations with unions at the national and local level.

Recommendation #2 - Request the Assistant Secretary for Finance and Planning to initiate an annual awards program for excellence in VA financial management. Categories should include, but may not be limited to excellence in billing and collection activities. These activities range from admissions screening to cashiering. Personnel involved in supporting functions such as IRM should also be eligible. Nominations should be entirely restricted to field personnel. Limits on repeat awards should be imposed. Awards for the top 10 individuals should be presented at an annual ceremony held in Washington, DC. The travel of recipients' spouses should be funded (CG B-233607) to enhance the award ceremony. Awards should include a combination of plaques, certificates, autographed photos, and $1,000 each as recommended earlier.

Consideration should also be given to a 'Billing and Collection Activity of the Year' award. An example of an award which may be presented is as follows. The Secretary could present the Annual Award to one VAMC which implements a model program for Third Party Collec-

tions. The honorary award could include recognition of the VAMCs top management as well as recognition of individual employees involved at the VAMC.

F. CMD Semi-Annual Awards - To encourage on-going efforts throughout the year and keep incentives visible, the CMD should establish semi-annual awards to recognize those individuals in VAMCs who perform the best in billing and collection. For ease of administration, these awards should be delegated to Regional Directors for selection and presentation.

Eighteen awards per Region per semi-annual period would be awarded for $500 each. This would provide a total of 126 individual awards per year and provide ample visibility to the billing and collection effort. A total of $63,000 should be centrally funded for this purpose.

> *Recommendation #3 - Establish semi-annual CMD awards for outstanding performance in the area of billing and/or collection. Eligibility for awards should include recognition of top management as well as individual employees involved at the VAMC. Selections should be made by Regional Directors based on nominations from Medical Center Directors. Recipients would be among those considered for annual Assistant Secretary awards. Criteria should be quantitative to the extent possible using some or all of the factors identified above. They should be consistent across Regions.*

G. Funding Innovative Proposals - VHS&RA should encourage, fund, and recognize innovative medical center proposals which improve MCCR collections. Proposals should be selected through an annual competitive process by requiring VAMC's to respond to an internal RFP. Proposals should include:

o A brief description of the proposal (who, what, where) to include personnel affected, organizational and other changes proposed, multi- or single facility involvement, etc.

o The reason for the proposal (why) to include a contrast between the current and proposed procedures and what benefits are anticipated as a result of the change.

o A description of evaluation criteria for measuring the success of the effort such as billing and collection rate changes, cost per dollar collected improvements, etc.

o The duration of the proposal (how long) should be outlined with start/stop dates and major milestone dates.

o The cost (how much) and method of financing should be described in a budget-like format. Shared funding between VACO and the Region and/or facility should be encouraged. If possible, the proposal should be funded by offsetting collections.

> *Recommendation #4 - VHS&RA should sponsor a competitive, internal RFP annually to encourage innovative changes which can improve the billing and collection functions. This should include at least partial funding support or, if possible, full funding by offsetting collections. Priority should be given to funding projects which involve multi-facility cooperative efforts. The MCCR Task Force successor group could judge proposals and recommend selections to 10B, the CMD, and/or Assistant Secretary for Budget and Finance. A total of $1,000,000 should be earmarked for these proposals.*

H. Local Performance Measures and Recognition Efforts - Performance standards should be revised to include a stonger emphasis on the billing and collection process for key staff members. This includes revisions to the performance plans for the Director, Associate Director, Chief, Fiscal, Chief, MAS and Section Chiefs responsible for billing and collection activities.

In addition, the functional statement for Utilization Review personnel should be rewritten to emphasize the importance of this program. Performance ratings and proficiencies should be

judged by the successful completion of key responsibilities.

Naturally, the weight given to billing and collection in assessing annual performance ratings should be kept in perspective with higher priority items such as quality assurance having more direct impact on patient care. The amount of incremental resources made available to Medical Centers in support of MCCR activities should also be considered.

Third Party Billing must be a critical element in performance plans of those employees whose duties are at least 50 percent involved in the program. The standard must be measureable based upon one or more of the criteria listed earlier.

Literature and discussions with private sector patient accounts managers suggests periodic non-recurring cash awards are among the most affective individual incentives. Locally, employees could be rewarded on a semi-annual basis for exceeding standards by receiving one half of a pre-defined annual incentive pool. An alternative could be a collection incentive sharing program thru which employees involved in billing and collection are given periodic special achievement awards based on the amount collected. The importance of rewarding the entire team of employees involved in the program should be stressed.

Directors of VHS&RA facilities should be encouraged and given wide latitude in establishing incentive award programs for employees involved in the billing and collection program. These awards would be over and above those recommended on a Regional or National level.

> *Recommendation #5 - Performance standards for managers as well as other employees should include MCCR program performance. Facility Directors should be encouraged to establish local awards programs for billing and collection activities. A designee from Management Support should be appointed to work with the Task Force's successor organization to develop detailed policies and procedures which will encourage these programs within VHS&RA.*

V. COST OF COLLECTION

A. FY91 Budget Initiative - Among the FY91 budget proposals, there is one to create a new appropriation for recovering the cost of billing and collection. The proposal would transfer up to 500 FTEE and $18.6 million from Medical Care to 'seed' the appropriation and add another 300 FTEE and $6.4 million to expand the program. Related FY91 legislative initiatives would give the VA authority to bill insurers of SC veterans who are treated for NSC conditions and collect NSC co-payments.

Thru February 28, 1990, medical centers have distributed 272.2 FTEE to the new Cost Distribution Report (CDR) account for billing and collection. The breakdown and annualized cost follows.

Cost Center	FTEE	Annualized Cost
286 Ward Administration	56.4	1,256,678
411 MAS - Office of Chf	20.6	693,299
414 Medical Records	75.4	1,713,334
421 Fiscal	95.1	2,829,093
419 QA/UR/Casemix	11.0	479,786
xxx Other	13.7	
Total -	272.2	

The 500 FTEE maximum proposed in the FY91 legislation is well in excess of the 191 FTEE funded in FY87 for means testing and 3rd party billing. It is also nearly double the FTEE and costs the field is reporting in CDR account 6016, Billing and Collection, through Febru-

ary 28, 1990. This reported cost, however, may be understated because of the late introduction of instructions to the field. In its present form, this initiative is likely to shift FTEE from other areas including direct care if all 500 FTEE were to be transferred.

Appropriations other than Medical Care support the billing and collection activity. This includes GOE and MAMOE appropriations. Budget and Finance, General and District Counsel, VACO-MAS, and others devote time and effort to billing and collection activities. Since the FTEE 'seeding' the new appropriation represents employees currently involved in the program, the Task Force recommends that expenditure transfers not be limited to Medical Care. They should be apportioned among Medical Care, MAMOE, and GOE. Moreover, actual expenditure transfers should be periodically monitored to insure each appropriation continues to devote its fair share of resources to the effort.

The additional 300 FTEE requested in the FY91 budget should represent new positions which will be used exclusively for the billing and collection program. A special tracking method should be employed during FY91 and FY92 to insure the 300 FTEE are used for new positions in billing and collection and not merely used to charge existing positions to the program.

The majority of the 300 FTEE should be assigned to VHS&RA field activities where the bulk of the work is performed. A smaller amount, 20 to 25, should be distributed to District Counsel offices in direct support of MCCR activities. The continued need for the latter FTEE should be evaluated in 2 to 3 years after the patient accounts program has more fully matured. General Counsel should consider designating regional or national referral centers which can provide specialized advice and on-site assistance to medical centers within a Region.

A few FTEE, 3 to 5, should be reserved for VACO program offices supporting the national aspects of the program. Another 5 or 6 FTEE should be assigned, on a time-limited basis, to ISCs for supporting the further development of an automated billing and collection package if a decision is made to internally develop the software. The majority of these FTEE should be redistributed to the field after the development work has been completed.

The Task Force suggests distributing FTEE to VHS&RA field activities using a three-stage method. One FTEE per facility (a total of 164 - 172 FTEE) would be funded to insure all activities are able to improve their commitment to the program. A small number of FTEE, about 30, should be earmarked to support selectees in the innovative project funding competition suggested earlier. The remaining 98 to 106 FTEE should be distributed based on performance in meeting collection targets and other criteria as identified earlier in the report.

The awarding of the additional 98 to 106 FTEE based on FY90 performance may give recipient facilities a perpetual benefit unless a periodic reappraisal of performance is conducted. It may be advisable to redistribute these FTEE periodically if recipient facilities drop precipitously in their performance standing.

> ***Recommendation #6 - If the FY91 budget proposal is approved, assess a portion of the NTE 500 FTEE 'seeding' to MAMOE and GOE as well as Medical Care. Insure new positions are established for each of the additional 300 FTEE appropriated. Reserve a small portion of the new FTEE for VACO and non-field use. Distribute the remainder to VHSRA field activities using a combination criteria of proration and performance as described in the body of the report. Monitor those charging expenses to the new appropriation to ensure a balance is maintained between the original 'seeding' and subsequent period charges.***

B. Adequacy of Passback Estimates - Documents shared with the Task Force on the FY91 OMB 'Passback' show collections projected to grow from $144,000,000 in FY90 to $949,000,000 in FY95. This includes the cost of billing and collection estimated to be $25,000,000 in FY91 and after. FTEE requirements are forecasted to be 500 in FY90 and 800 each year thereaf-

ter. The data presented in the passback is troubling for two reasons.

1. Collection Estimates - First, estimates so far produced as to collection potential have been based on extrapolations from very limited data sets. For instance, a collection estimate by BIRCH AND DAVIS was based on a limited study of VAMC Richmond's program. A later study by Besecker, et. al. used the Survey of Veterans III (SOV III) data base collected in 1987. Besecker Study collection estimates ranged from $464 to $1,145 million per annum.

Existing data sets do not identify the limits of insurance coverage, the volume of treatment rendered for NSC conditions, and other facts needed to make accurate estimates.

During the last meeting of the Task Force, members of the Management Science Group presented information on the survey methodology and sample size used in SOV III. They also presented preliminary results of a more recent study called 'Survey of Medical Systems Users (SMSU) taken in 1988. SMSU limited itself to users of VAMCs unlike SOV III.

The findings of SMSU were significantly different than SOV III with regard to veterans with no private health insurance coverage. SOV III indicated 60 percent of veterans under 65 had no health insurance versus 69 percent in SMSU. SOV III stated that 46 percent of veterans over 65 had no health insurance versus 64 percent for SMSU. Since the sample used in SMSU was more targeted to the VA medical population, it is likely billing and collection estimates would be more accurately stated using this data.

Additionally, the number of insured veterans and limits of coverage are constantly changing in response to rate and plan changes. Nationwide, it is estimated that as many as 1 million citizens drop their health insurance coverage each year. None of the estimates produced to date, therefore, can be entirely relied upon.

There is no indication the estimates in the passback are more exact than those described above.

2. Cost Per Dollar Collected - According to the passback, the cost of collection in FY90 is estimated to be 11.4 cents per dollar collected. This cost is based on the $18.6 million which will be transferred from Medical Care to the new appropriation if established. This is scheduled to decrease to 2.6 cents by FY95 - a 77 percent decrease. Certainly, there will be economies of scale as volume increases and efficiencies as policies and procedures are better defined. There is no evidence to suggest, however, that cost per dollar collected will decrease by this much.

Most States require hospitals to file cost reports with local regulatory authorities each year. Many such as Massachusetts include a line item for billing, collection and admission costs. By reviewing this data, VHS&RA could become acquainted with the cost of billing and collection per dollar of net patient service revenue that non-VA hospitals are able to achieve. Allowances would have to be made for the economies of scale and experience benefiting non-VA hospitals and the less complex, per diem/visit based billing permitted for VAMCs.

> ***Recommendation #7 - VA should be wary of relying on estimates made to date for total collections and cost per dollar collected. Further, any national budget reconciliation which relies on them should make known this caveat. Supporting papers from which cost of collection estimates were created should be examined by knowledgeable experts. Comparisons on cost per dollar collected should be made with private health care sector activities.***

C. Commercial Billing and Collection Services - Congressional testimony suggests a desire for the DVA to use commercial billing and collection agencies for third party collections. An early version of H.R.901 which was endorsed by many members of the House Committee on Veterans Affairs stated:

"...the Secretary shall use services of the private sector to the maximum extent feasible."

"The report shall be based on a study, to be done in consultation with the Comptroller General of the U.S., comparing the experience in carrying out...this subsection through the use of contractor services at not more than 20 medical centers."

This language was deleted from the law prior to its passage, but gives a sense of Congressional thinking.

General Counsel has advised VHS&RA that third party collections cannot presently be used to pay for billing and collection services. One impediment stems from the distinction between commercial debt and medical claims. The current GSA contract relates to commercial collection services for delinquent accounts. It is believed by Government legal and procurement authorities that this contract does not apply to medical care claims.

A medical center could chose to pay for the services from medical care funds, but most lack the discretionary funds to make this option viable.

Two commercial firms were invited to a meeting of the Task Force to discuss services and fees they could offer if VHS&RA elected to contract out some of its third party activity. The services ranged from from collection only to all inclusive services. The latter would cover the complete billing and collection cycle including the identification of billable cases.

Fees for the services would be fixed per account or based on a percentage of collections. The two contractors interviewed indicated contingency fees would be lowered substantially from the initial 30 percent of collections as more experience is gained.

A 30 percent contingency fee is vastly higher than the highest estimate of 11.4 cents per dollar collected given in the OMB passback for in-house costs of collection. It is also well in excess of the 1 to 2 cents per dollar collected cost which is commonly spent by non-DVA hospitals.

Despite the cost difference, it may well be to VHS&RA's advantage to employ commercial services for the following reasons:

1. Unbilled Cases - Many billable cases are not being identified by VAMCs because of limited resources or ineffective screening. Most insurance carriers will not honor claims submitted more than one year after the medical care was rendered. Each year, VHS&RA will lose the opportunity to bill and collect millions of dollars if this problem is not solved. One solution would be contracting with a commercial firm to screen a list of NSC patients who have not been billed, but received DVA medical services. This list could be filtered to include only NSC inpatients with lengths of stay over 'X' days or other conditions with highest billing potential.

2. Doubtful Accounts - Commercial firms may be able to collect on accounts for which VHS&RA is terminating collection. This would be especially applicable for those involving large amounts.

3. Pilot Programs - Commercial firms have a base of experience and resources which VHS&RA facilities are only beginning to develop. By contracting with commercial firms to substitute or supplement VHS&RA billing and collection activities, VHS&RA would be able to observe the billing and collection efficiency of commercial firms. This would especially be inviting in areas such as Southern California where VHS&RA collection efforts have not been strong. These pilots could also provide information which could be used if A-76 studies are required in this area.

It also seems prudent for VHS&RA to determine as soon as possible whether commercial services are more cost effective than inhouse programs. Building an inhouse program only to later discover that commercial services are more cost effective would present personnel issues regarding the dismantling of the inhouse program.

> ***Recommendation #8 - Set-aside $180,000 (of the $2 million earmarked) to pilot the use of commercial billing and collection services at one or more medical centers the second half of FY90. The services should include unbilled cases, doubtful accounts, and full billing and collection services. The cost and benefits of using commercial versus in-house services should be carefully evaluated by an objective study group.***

D. Other Private Sector Services - Some private medical centers are turning to cooperatives as an alternative to independent collection agencies. These organizations are generally geared to doubtful accounts. An example is the 'Hospital Credit Exchange', a for-profit subsidiary of the Greater New York Hospital Association in New York City.

These organizations may provide a source of commercial billing and collection services for the DVA. They may also provide a model for the DVA to pilot its own multi-facility billing and collection cooperative. Several variations are possible for in-house programs depending on the range of services the cooperative would offer.

There are also services available for electronic billing and verification of insurance coverage. VAMCs Richmond, Salem and Hampton have reported success in using these services. Other VAMCs should consider using them.

Many private sector patient account managers belong to the American Guild of Patient Account Managers (AGPAM) headquartered in Washington, DC. This organization could be a useful source of educational and other professional information. Among the benefits offered to members are:

- o A bimonthly journal on patient accounts management
- o Professional education seminars and workshops
- o Special interest groups
- o Professional certification
- o Information exchange
- o National institute and annual meeting
- o Technical training and certification
- o Interaction and networking with peers
- o Local chapters and meetings in 43 of 50 States

VHS&RA may wish to encourage membership in AGPAM to improve the professional stature and education of its employees engaged in managing patient accounts.

The Chairman of the Task Force reviewed one private sector medical center's billing and collection department. The organization chart is attached. The following statistics were recorded for FY89:

Workload	- 40,000 outpatient visits
	- 14,000 acute hospital discharges
Revenue	- $196 million in gross patient service revenue
	- $137 million in net patient service revenue after allowing for contractuals, free care, and doubtful accounts.

Billing and Collection Dept FTEE - 41.0 (see org. chart).
Discharges per Inpatient Biller - 3,500 or 14/workday
Visits per Outpatient Biller - 6,700 or 26/workday

The cost per dollar collected was about 1 cent. This did not include medical records, admissions, data processing and other costs not directly incurred by the billing and collection department which are assumed to be in the DVA figure. Even if these costs are built-in, the cost per dollar collected is much lower than DVA projections.

This suggests the traditional DVA billing and collection organization may not be optimal in terms of its cost efficiency. It is important for the DVA to experiment with various options. This includes multi-facility billing and collection cooperatives, enhanced data processing techniques, document work flow, functional assignments and others to streamline billing and collection to the extent possible.

The processing of a third party billing currently requires many individuals to become involved. There may be opportunities for improving the process without compromising internal control. For example, DVA could consider releasing the bill directly from MAS to the third party with an information copy to accounting for recording in the general ledger. In private sector medical centers, it is common for patient accounts to only pass end of month totals to accounting for posting to the general ledger.

Most States require non-DVA medical centers to report costs annually to regulatory bodies. In some cases such as Massachusetts, this data contains information on the cost of billing and collection. This is another source of information VHS&RA should monitor to ensure its inhouse program is cost effective.

> *Recommendation #9 - Among the innovative pilot programs funded through national competition (re: Recommendation #4), include one or more multi-facility cooperative programs especially in New York, Los Angeles, Chicago or other major urban centers. The Task Force's successor should investigate the services offered by commercial firms and, if warranted, pilot their use. Assign some group or outside contractor the responsibility of completing a thorough review of DVA's billing and collection apparatus.*

E. Definition of Cost of Billing and Collection - There are three categories of collections in which VHS&RA becomes involved:

- o fees charged to third parties such as sharing agreements.
- o amounts recoverable by the U.S. under section 629 of title 38 USC such as third party reimbursable insurance; and
- o amounts collected from Category B and C veterans such as medical deductibles and copayments proposed for FY91.

The billing and collection resources devoted to each of these categories often overlap and are difficult to separate. Because of this, the Task Force highly endorses the language used in the legislative proposal for the new FY91 appropriation.

In the proposed language, the new appropriation would cover the cost of all types of MCCR-related collections except sharing. Covered expenses would include overhead associated with the following collections: crimes of personal violence, humanitarian, no fault automobile claims, workers' compensation, tort claims, ineligible veterans, third party insurance, means test deductibles, and means test co-payments.

Expenses for sharing are not included because they are already recoverable by the DVA. These collections are reimbursements to medical care and sharing rates presumably include allowances for administration.

F. CDR Account 6016 - In FY90 a new Cost Distribution Report (CDR) account was established to account for the administrative costs of third party insurance billing and collection. The definition for this account should be expanded to include deductibles, co-payments, ineligibles, and other MCCR collections which will be covered by the proposed new appro-

priation.

By defining the costs for the new CDR account to be the same as those chargeable to the new appropriation, it can be used to identify the expenses to be transferred from medical care.

In addition, charges to the CDR account which are now limited to 400 series cost centers should be expanded to allow for 200, 600, and 700 series cost centers. If this is not done, duties performed by admissions personnel, social workers, and others in identifying billable cases; work performed by ISC's in developing and maintaining MCCR and Accounts Receivable software; and other related activities and equipment will not be reflected in the cost of program administration.

Recommendation #10 - Redefine CDR account 6016 to include the cost of billing and collecting 1st party medical copayments and deductibles. Allow 200, 600, and 700 series cost centers as well as 400 series cost centers to be charged to this CDR account.

VI. TRAINING

Another major inadequacy of the VA billing and collection effort is the lack of education and training programs and materials. Training needs include use of MCCR and IFCAP accounts receivable software, methods for identifying billable cases, collection techniques, and many other technical topics. Added to this, field managers are generally unaware of the direct linkage between third party collections and VHS&RA's budget authority.

The Task Force has identified a number of actions which can improve this situation. Most will require a resource commitment by VHS&RA until such time as offsets to collections can be made.

A. RMEC Sponsored National Training - A limited amount of medical care funding has been made available for national training in FY90. The Acting Director, MAS who is also a member of the Task Force serves on the planning committee. This planning committee will work with the Northport RMEC to design a course of instruction to be offered later in FY90 for VHS&RA field personnel. Training material will include a 'how to' handbook on billing and collection procedures. Additional resources, especially travel funds, may be needed to effectively carry out training programs.

B. Electronic Mail Group and Newsletters - The Task Force has begun an electronic mail group on FORUM (G.MCCR MAIL GROUP) dedicated to sharing informal advice on billing and collection policies and procedures. The Task Force suggest that a newsletter be periodically distributed by mail or FORUM to interested parties.

C. Canned Education Programs - Many third party payors have training material which they use for internal use in educating employees on the scope and limits of their health coverage and reimbursement fees. Cheryl Hoffman, a member of the Task Force, has surveyed major payors for training materials and reimbursement criteria. After the data is cataloged, she will present it to the VHS&RA program coordinator for further use.

D. Management Education - There is a need to educate facility management on the impact of Third Party Collections on the VHS&RA budget. This could be done at annual meetings, weekly conference calls, publications, and other media. Generally, few people are aware of the direct linkage between the VA share of the Federal budget and estimates of MCCR collections.

E. Annual Training Conference - An annual training conference should be held for 30-40 people representing field and VACO personnel involved in billing and collection. Field representation should be a mixture of disciplines and types of medical centers. Speakers from non-DVA activities knowledgable about patient accounts management should be invited to

add depth to the presentations. Dialog on what works and does not work would be chronicled and published for all medical centers. Suggestions for policy and procedure changes, training programs, and other activities which can improve the billing and collection program should be developed. The meeting should be funded by offsetting third party collections if legally permitted.

F. Reference and Assist Teams - Employees with special expertise in billing and collection activities should be designated as national reference specialists. This designation should be added to their position description (incumbent only) with a commensurate grade and pay increase. These employees would be marketed to the field at large as reference sources who can be called for advice, instructor support, and operational assistance. In addition, they would be used to form 2-4 person 'assist' teams which could visit problem facilities and render advice, training, and operational assistance. The cost of these efforts should be underwritten by centrally funded medical care funds or offset from third party collections.

G. Private Sector Support - Since private sector medical centers have more experience in patient accounts management, key VA staff such as those designated as field reference points should be encouraged to attend privately sponsored training programs. All facilities should be encouraged to participate in local patient accounts management, health care financial management, and other associations such as the American Guild of Patient Account Managers which can increase their knowledge of billing and collection activities. The fees and other expenses associated with these activities should be underwritten by centrally directed funds or charged against amounts collected.

H. Monthly Conference Calls - Presently, information regarding new policies, informal advisories on special problems, etc. are delivered over MAS, Fiscal, and other national conference calls. Billing and collection employees do not always know when topics related to their activity will be discussed. Information which is provided on Fiscal conference calls may not be shared with MAS employees and vice versa. To correct this problem, the Task Force initiated a monthly nationwide conference which began February 12, 1990 and the second Monday of each month thereafter.

I. Billing and Collection Checklist - Most other activities within medical centers have SCEM checklists to self-evaluate their operations. A SCEM checklist should be developed for the billing and collection program. A primary charge of the MCCR Task Force successor organization should be the development of SCEMS for facility directors to use in the initial evaluation/assessment of local medical care cost recovery programs and for yearly reviews as required by M-1, Part I, Chapter 15, Paragraph 15.03. In addition, medical care cost recovery assist teams can utilize and continue to improve SCEMS as necessary.

Recommendation #11 - VHS&RA should endorse and support with resources as necessary the following training and education activities related to Medical Care Cost Recovery -

- *RMEC sponsored education including 'how to' manuals*
- *E-mail groups and newsletters*
- *Canned education programs*
- *Top management education programs*
- *Annual meetings of selected billing and collection personnel*
- *Reference/assist teams*
- *Private sector educational assistance*
- *Monthly conference calls*
- *Self-evaluation checklists (SCEMS)*

The support should include a willingness to commit medical care resources if legislative authority to offset collections is not granted. The Task Force's successor organization should work with appropriate VACO officials to more fully develop implementation policies and

procedures.

VII. BILLING IDENTIFICATION

One training and education need deserves special attention. It relates to the identification of billable cases. Meeting this need requires a combination of employee, patient, and veteran-advocacy group education.

A. Patient Education - Because we cannot bill for uncovered care or deny benefits if the patient does not disclose insurance coverage, we need to encourage patients to acknowledge third party coverage. In discussions with field personnel, the Task Force learned that some patients fear they will be billed for the portion of the bill their insurance company does not pay. Others believe their health insurance rates will increase especially if they belong to a small union or association sponsored plan.

The Task Force is working on the development of a patient pamphlet which would educate our constituents on the need for 3rd party billing and how it is done. A member of the Task Force, Cheryl Hoffman, has contacted an individual who will prototype a pamphlet. After the pamphlet is developed, a successor group to the Task Force should work with the Learning Resources Center or a RMEC to develop a short videotape. The video would be used in outpatient waiting areas and other suitable locations to educate veterans about the MCCR billing program.

To ensure the pamphlet and video are appropriate for DVA-wide use, it should be cleared through VACO public affairs specialists.

B. Letter to Veteran Service Organizations - The Task Force believes dialog with the VSOs needs improving to enlist their support in educating veterans on the importance of disclosing third party insurance coverage. The Task Force believes this should be organized by VACO public affairs specialists because of the sensitivity of this matter for many VSOs.

> *Recommendation #12 - Designees from Learning Resources and Public Affairs should be designated to work with the Task Force's successor to continue the development of patient and VSO education material which will help them better understand and cooperate in the MCCR effort.*

C. Patient Screening by DVA Staff - Perhaps the most important function in VA's billing and collection process is identifying billable cases. This is not easy as pointed out earlier. Veterans do not have to disclose insurance information and no financial liability accrues to eligible veterans except small deductibles and copayments (proposed) for category B and C veterans.

There are several suggestions that have been made in previous reports and program letters that should be reiterated to the field. Among them are:

1. Use effective interview techniques when processing an initial application for care. Asking for information on insurance early in the interview process, using a proactive interview technique such as "do you or your spouse have health insurance?" rather than "you don't have health insurance do you?". A good videotape is "You Make a Difference" available from the National Association of Admitting Managers, 1986, 14 minutes.

2. Request social workers to cross-check insurance information during the discharge planning process.

3. Ask nurses, physicians and other care givers to notify billing if they identify insurance coverage during the course of care.

4. Request Release of Information Coordinators to alert the billing unit if an insurance carrier requests information.

5. Conduct an effective pre-admission program for all elective admissions. This should include asking veterans to send insurance information prior to admission or bring it with them. Reminders should also be included on all reminder letters for appointments.

6. Review admission folders and re-interview veterans on the ward where you suspect insurance coverage is available.

7. Contact employers of veterans and employers of the veteran's spouse to see if health insurance coverage is active.

8. Review previous releases of information, 10-10f's Financial Worksheets, 10-10's Application for Medical Benefits, and 10-10i's Insurance Information to see if information on the current forms may have been entered in error.

9. Work closely with third party payors to gain familiarity with policy coverage limits, points of contact, and other information which will improve collections.

10. Facilities need to work with their District Counsel in negotiating participating membership status with Blue Cross/Blue Shield plans and possibly preferred providor arrangements with these and other payors.

Services are also available which can verify commercial health insurance coverage through private data bases. DVA needs to explore the use and cost of these services more aggressively. This may include screening all non-billed CAT A-NSC, B, and C patients through a verification service when a medical center has an exceptionally low billing rate (refer also to recommendation #8).

Recommendation 13 - Training activities need to emphasize the importance of identifying billable cases prior to the patient completing the episode of care. Facilities should also be encouraged to establish participating providor agreements and work more closely with local payors. Commercial verification programs should be used where the cost is likely to be recovered such as for facilities with low billings, yet numerous high cost inpatient NSC treatments.

D. Patient Processing - The scheduling, registration, and tracking mechanism for processing patients needs improvement. This is especially true for outpatient and non-bed care. For example, the IG has cited a material weakness in the DHCP outpatient scheduling software pertaining to 'no show' activity.

Few, if any, medical centers code procedure or diagnostic codes for outpatients. Both are now required for Medicare billing. Methods for data input are still labor intensive and do not use bar coding, light pen, machine readable identity cards or other technology. Similarly, standardized diagnosis and procedure forms commonly used in private health care clinics are not in wide use within the DVA.

These software handicaps will hinder DVA's ability to identify patients, identify services performed, improve the billing rate structure, and meet the requirements of new legislation. An example of the latter is the expansion of third party insurance to SC veterans treated for NSC conditions.

These deficiencies impact upon other VHS&RA efforts including DMMS, QA/UR, Planning, and Resource Management. Each of these activities would benefit appreciably if outpatient processing were improved.

***Recommendation #14** - The Chief Medical Director should charge MIRMO and MAS with the responsibility for developing and accelerating the introduction of an improved scheduling, registration, and tracking system for non-acute bed care workload. Among the improvements, there should be a better means for identifying patients, identifying services performed to include diagnostic and procedure codes, and handing data off to an improved billing and collection system. The new system should provide for hardware and software which can use labor saving technology such as the outpatient cd-rom card under study at the Troy ISC.*

VIII. MANAGEMENT INFORMATION

When the Task Force researched cost recovery activities, it became clear that an adequate data base for informed management decision making was lacking. On a national scale, there is no data base which combines billing and collection data by payor, veteran eligibility, type of care, denial code or other information which would typically be found in a private sector patient accounts management system.

A. MIS Deficiencies - Among the problems this deficiency creates are:

o Estimates of collections are limited to extrapolations from small, sometimes non-random samples. There has not been an estimate of collections produced which would withstand the scrutiny given to a commercial business plan.

o Collection targets assigned to Regions and medical centers do not recognize payor mix (medicare, HMO, etc.), patient mix (how many have insurance), treatment patterns (how expensive was the care), and other factors which influence collections.

o Account receivable trends cannot be assessed such as whether delinquency problems are developing for certain payors or at certain facilities.

o Benefits of legal action such as the successful negotiation with AARP and Prudential regarding Medigap payment cannot be determined.

o Adequate data needed to measure the performance of individual medical centers in billing and collection activities is missing. VA program officials must rely on the more primitive, less timely, and less reliable AMIS data rather than extract data from records of original entry in CALM and PTF.

o Data needed to estimate the impact of new legislative proposals such as the introduction of copayments for category 'B' and 'C' veterans and third party collections to SC veterans treated for NSC conditions is largely lacking.

At a medical center level, reports which can improve the identification of billable cases and collection efforts are not routinely available. Many reports that are available are not well understood by managers or easily accessible.

The Task Force has several recommendations which it believes can improve this situation.

B. Local MIS Needs - On a local scale, the Task Force recommends the following reports be added to DHCP MCCR and IFCAP Accounts Receivable (AR) software:

o Date PTF Closed versus Date Patient Discharged - This is available in the "PTF Record Listing" option. It will enable management to track lost account receivable days due to records not being completed by physicians in a timely manner, delays in UR, delays in medical records, or similar delays.

o Patients Who Have Insurance but PTF not Closed Out - This will allow management

to concentrate on those medical records which can generate cost recovery revenue.

o Spousal Employment - This would identify patients who said they have no insurance, but have spouses who are employed. Checks could be made with the veterans spouse or employer as to the availability of health insurance coverage.

o Patients Employed but Have no Insurance - This will allow a search to verify if a patient truly has no insurance. The station will then have the option to contact the patient's employer or spouse's employer to verify the information.

o NSC Veteran Who Has Never Responded to Insurance Questions - This report will allow the medical center to see those patients who it must contact again. This will potentially create a larger data base for cost recovery.

o Billing Tracking Mechanism - From point of service (discharge, outpatient visit date, LTC days at 30 day intervals) - to - date PTF closed (for discharges) - to - date of initial billing review - to - date bill authorized then - to - AR. This will require interfacing the MCCR and AR software by the Albany and Washington ISC's.

o Category C Means Test - An existing report in the MAS software indicates, by name, a patient's billing activity. It might be beneficial to add a prompt to this software so that Category C veterans who owe money are the only ones listed.

o Means Test Category Insurance Listing - This proposed report would summarize by means test category the number of veterans who have insurance coverage against all veterans in that group. Only NSC veterans would be searched at present (SC to be added later if the law changes). These data, coupled with station specific length of stay and outpatient data, can be used for a more stringent cost recovery breakout at the regional and station level.

o Account Receivables by Dollar Amount - This would allow a data search of accounts receivable greater than "X" dollars. This would enable the station to concentrate on large outstanding balances of its choice.

o Aging by Third Party Carrier - This report would track the promptness of third party carriers' payments and indicate on which carriers the station must concentrate.

o As a subset to the above report, a report of Collections versus Accounts Receivable could be generated by payor class. This report could focus on dollar amounts and the number of bills over a specified time period. Since collections are heavily influenced by payor class, this would give a truer indicator of outstanding activity.

o Billing Error Rates - Presently, the "Returned Bill List" allows one to track cancelled bills and to whom they were returned.

C. National MIS Needs - In addition to local improvements, a national data base needs to be developed so that informed policy decisions can be made and field performance can be monitored. This data base needs to combine patient and accounts receivable data in a form which can be timely, readily and flexibly accessed.

Since medical centers are working with a variety of accounts receivable systems including PC-based, IFCAP-based, and manual record keeping, the Task Force believes augmenting data maintained at the Austin DPC would be the best short term solution to the need for national data.

Most of the data necessary for a national data base is already on the Austin DPC system in either the CALM, PTF, or OPC files. A few items need to be added including a key field which can be used to join the CALM files with the PTF and OPC files.

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Data which is missing from the current CALM and/or PTF/OPC records include payor class, denial codes, and purpose for the billing. These codes indicate who was billed and the reason why payment was not made in full. The PTF and OPC files also lack reference to the accounts receivable PAT number. Without this, the workload, billing, and collection data cannot be joined.

If the missing items were supplied, a national file would be available on-line which would provide a complete breakout of billings and collections by type of patient, type of payor, inpatient diagnostic code, and much more.

The Task Force believes these modifications can be accomplished in one or a combination of the following ways:

o Preferably, modify the CALM transaction type 939 - Receivables - General Fund Receipts to identify payor class, i.e. medicare supplemental, Blue Cross/Blue Shield, other commercial insurance, HMO, self-pay, etc. and eligibilty class of the patient, i.e. Category C - NSC veteran outpatient care, Cat C - NSC vet hospital care, worker's compensation, NSC with health insurance, crime of personal violence, and so forth.

o An alternative is having each Medical Center create a data file with the following elements which could be used to join and augment the workload (PTF and OPC) and receivable (CALM) files. The data elements in the new file are:

Station Number	Patient SSN
Type Episode	Type Billing
Episode Date	Denial Code
Status of Payment Code	Primary Payor Code

A separate record would be created for each receivable PAT associated with a patient's episode of care. This new data would be joined with PTF/OPC and CALM data available at Austin to provide a more complete information source on MCCR activities.

The Task Force has initiated a small pilot study involving 6 medical centers to verify the feasibility and work required by this approach.

o Yet another alternative is modifying the PTF and OPC files by adding a field to cross-reference the PAT numbers of receivables associated with a particular discharge or visit. Because of interim billings for long term patients, several PAT's may be associated with a particular stay. For this reason it may be better to build a separate file as described above.

These modifications would permit the automatic generation of AMIS segments 243-9. This would not only make this data more timely and accurate, but would relieve the medical centers of the workload associated with these AMIS segments. The data would also be on-line so that it could be analyzed using data base tools.

The consolidated data set could be maintained in any of several locations including the Boston Development Center and Troy ISC. The prerequisites for selecting the servicing site should be adequate communications and processing power to accommodate VACO, Region, and station-level users. Additionally, a 4th generation data base language such as Oracle should be available for data inquiry.

Note: The Task Force understands that CALM is being replaced by FMS within the next 2-3 years, optimally. This has created a reluctance on the part of CALM system managers to invest resources in changing CALM. The Task Force hopes these recommendations will be viewed with the priority Congress, OMB, the Secretary, and the Chief Medical Director have

assigned to MCCR activities.

D. Make versus Buy Decision - Among the discussions of VHR&RA's Strategic Information Systems Plan (SISP) Committee was one regarding make/buy decisions for new or replacement software. The sense of the Committee was that VHS&RA should always compare the cost and features of commercial software to in-house production costs whenever a major software development program is considered.

Private sector health care has considerably more experience in managing patient accounts than does VHS&RA. Because of this, their software is likely to be more mature and full featured. Private sector receivable software is also more likely to have capabilities VHS&RA may not currently need, but will need in the future as the sophistication and requirements of our MCCR program increase.

It would seem prudent for VHS&RA to carefully evaluate the cost, benefits, and features of commercially available patient accounts management software before embarking on an in-house redevelopment effort.

E. MIS Needed for FY91 Budget Initiatives - Among the legislative proposals contained in the FY91 budget package is authority to collect third-party reimbursements from insurers of SC veterans for treatment of NSC illnesses. This includes all types of medical care provided by DVA. At the present time, DVA data sources cannot distinguish if a veteran patient was treated for a service-connected disability or NSC illness. This is true for outpatient, nursing home, and many other treatment types.

This information gap prevents DVA from making accurate estimates of collections, identifying billable patients base on treatment rendered, or assessing the impact of the budget initiative if legislated.

> *Recommendation #15 - A number of enhancements should be made to DHCP and central systems to support improved data tracking and reporting as well as more sophisticated patient accounts management. An Applications Requirements Group (ARG) should be formed within 30 days to identify short-term requirements. Among the requirements to be addressed are those mentioned in paragraph VIII (A - E) above. MIRMO and/or managers of central systems should then identify resource needs to fast-track delivery of necessary products. The features, cost, and delivery schedule of commercial software should be examined by the ARG as they consider development options. The program costs should be offset against collections if this authority arises.*

F. Third Party Billing for Certain SC Veteran Care - The budget proposal for billing insurers of SC veterans treated for NSC conditions can also present some sticky issues for clinicians and MAS staff. For example, billing rates are now based on visit and per diem rates. It is quite feasible a SC veteran may be treated during one episode of care for both SC related and NSC related conditions. For example, one or more clinic stops within an outpatient visit, i.e. episode of care, may be related to an SC disability while others related to NSC illnesses. This same may be true of inpatient stays.

There is no provision in the current rate structure for customized charges which may be needed to split out the cost of NSC treatment only. Even if the rate structure did allow for this, making the clinical/administrative determination as to which applies is a knotty problem.

> *Recommendation #16 - The FY91 budget proposal should be amended to provide billing authority if the 'dominant' portion of an episode of care is related to a NSC illness or injury. As the VA's patient accounting system matures, consideration should again be given to charging only for tests, procedures, clinics, and days of care associated with NSC conditions.*

IX. FINANCIAL ACCOUNTING

A. VA General Ledger Deficiencies - The accounts receivable general ledger structure for general fund receipts is as follows.

1221.03 - Opening Balance - Current Fiscal Year
1221.04 - Establishments or Adjustments
1221.05 - Collections or Offsets
1221.06 - Collection Actions Terminated or Waived
1221.07 - Reported to GAO

These modifier codes were defined prior to PL 99-272 and lack the robustness needed to identify reasons for payment denials, adjustments, and other actions influencing collection rates.

Additionally, the CALM general ledger has no account comparable to the contra (offset) account maintained by private sector medical centers for contractuals and discounts. It is the practice both outside and within the DVA to record patient accounts receivable in gross. In the private sector, a contra account reduces the amount of receivables by contractual limits or discounts expected to occur.

Since the DVA makes no allowance for contractuals, accounts receivable are overstated for patients covered by Medicare, HMOs, and others. DVA adjusts receivables to the liability limit of the payor only after the claim is settled. This causes most current receivables to be overstated.

This deficiency naturally influences VHS&RA's ability to achieve the 80% collection rates sought for FY91. It also limits the management information which can be gleened from national data. For example, 'days in accounts receivable' which is a key indicator for private sector patient accounts managers cannot be properly calculated. This indicator must be calculated by dividing the average collections per day into patient accounts revenue after deducting for contractuals, discounts and allowances for doubtful accounts.

Recommendation #17 - To improve the functionality of the DVA general ledger account structure, the Task Force recommends the Deputy Assistant Secretary for Finanial Management (047) expand the use of general ledger modifier codes. The new codes would be used for identifying the class of adjustment or denial code. Further, a modifier code or separate general ledger account should be established to estimate differences between gross receivables and collections due because of insurance coverage limits. The Task Force recognizes the difficulty in changing the current COBOL-based financial software. This notwithstanding, we believe this change is necessary to avoid overstating receivables and provide needed management information.

To represent a more accurate collection rate, the following 'official' formula should be used for computing collection rates:

$$\frac{\text{collections}}{\text{gross receivables less allowances for 'contractuals'}}$$

This will adjust for Medicare coverage, HMO coverage, and other allowances known at the time the bill is issued. 'Days in accounts receivable' should also be computed net of 'contractuals' as is the practice in private health care activities.

B. Allowance for Doubtful Accounts - Another deficiency in the VA general ledger exists in the manner doubtful account allowances are recorded. This account is maintained in the 'Other Series' of general ledger accounts. Consequently, it contains no information on doubt-

ful account estimates by appropriation, fund, or fiscal year. Doubtful accounts are likely to arise for receivables involving deductibles, copayments, ineligible hospitalization and others. Improving the structure of the general ledger in this area will improve management information and likely lead to improved estimates of doubtful accounts.

> ***Recommendation #18 - The Deputy Assistant Secretary for Financial Management (047) should establish subsidiary accounts for general ledger account 2236 and/or 4018 to differentiate, at a minimum, the allowance for doubtful accounts estimated for current and past year medical care appropriations and general fund receivables associated with MCCR collection, e.g. ineligibles, means test, etc. One method for doing this would be adding suffixes, e.g. .01, .02, etc. much the same as those used with GL account 1221.***

X. RATE SETTING POLICY

The Task Force reviewed the current rate setting policy and identified three areas where deficiencies exist. They are:

- o Timeliness with which new rates are published,
- o Computational accuracy of the current rate structure, and
- o Methodology used in the current rate structure.

A. Delays in Publishing Billing Rates - Each year VHS&RA (MAS) requests the Resource Planning Service (043) to develop new rates for the forthcoming fiscal year. This request is made in February; eight months prior to the start of the fiscal year. After coordinating the rates with VHS&RA, Resource Planning Service submits the rates to OMB for approval through the Office of the Secretary.

This year, new rates were not published in the Federal Register until January 1990; 102 days after the fiscal year started. Not only does this foster charges of Governmental ineptness, but, more importantly, it results in higher costs to the taxpayer.

Many medical center finance officers delay billings until new rates are published to avoid double work. Alternatively, they publish bills at old rates and never bill the difference when new rates are published. When new rates are published this late, payors are given the equivalent of an interest free loan. This can represent as much as $75 million in delayed deposits and the consequential increase in Treasury borrowing costs. This cost will increase in future years as MCCR billings increase.

In contrast, HCFA Prospective Payment System rate adjustments are routinely published without delay in the Federal Register on September 1st to allow adequate time for implementation on October 1st. The structure of VA rates is much less complicated than HCFA's and involves only a few variables which will be discussed later. There is no apparent reason why these rates could not be published well in advance of the fiscal year.

The publication of DVA rates is coordinated with those of other Federal health care providors. This can delay publication of rates if the other parties are tardy.

The Task Force believes the entire rate setting process should be an internal VA action. DVA should have the authority to adjust its rates, perhaps subject to certain limits, and publish them without requesting OMB approval. This would disengage DVA rate setting from other Departments and Agencies and avoid delays.

> ***Recommendation #19 - The Assistant Secretary for Finance and Planning should request authority to disengage DVA rate setting from other Federal hospitals and eliminate the need to request OMB approval for new rates. If this is not possible, a firm schedule*** should be

agreed upon among involved parties including OMB to ensure new rates are published by September 1st each year.

B. Current Rate Structure - The Task Force reviewed the computations used in the current rate structure. Identified deficiencies tend to understate rates and result in lost collections. A few overstate rates and may make DVA vulnerable to counter-claims by third party payors.

The rate setting computation is quite simple involving only five variables -

- o Actual prior year cost including depreciation from the Cost Distribution Report (CDR),
- o Actual prior year workload from the CDR/AMIS,
- o Transitional adjustments for current and budget years to account for inflation and other unspecified factors,
- o An overhead adjustment to allow for support costs not included in the CDR,
- o Interest on capital and unfunded fringe benefit adjustments to account for costs not charged to VA appropriations.

Using an electronic spreadsheet, the rates for each of the 13 program areas can be computed in seconds once the values for each of the above variables is known. Each of the variables, however, has potential deficiencies.

1. Inappropriate Costing - When FY90 billing rates were calculated, actual prior year cost excluded over $1.79 billion or 18.2% of total medical care jurisdictional costs. Among costs excluded were prosthetics, care authorized at DVA expense by non-DVA providers, off-site DVA staff care such as home based health care, miscellaneous benefits and services including beneficiary travel and District/Regional support, and cost of services furnished to non-VHS&RA activities such as the National Cemetery and sharing recipients.

Only the last category of expenses clearly does not belong as part of the rate structure. For the most part they are non-medical care expenses incurred to support VARO, Cemetery, and other activities. These would normally be classified as non-operating expenses in the private sector and excluded from their rate structure. Similarly, expenses associated with approved sharing contracts are already reimbursed.

There are cogent arguments for not excluding all or some of the other expenses. In excluding prosthetics and non-DVA care, policy makers directed facilities to add these to charges on an actual expense basis. This presumes a cost and service tracking system that most DVA facilities do not possess. It is doubtful, for example, that any of $86 million in DVA salary expense charged to the prosthetic and non-VA care accounts is billed by medical centers. While this expense only represents 1.1 percent of included costs, on a collection base of $300 million it potentially represents $3.1 million in lost revenue annually.

None of the $73 million in expenses for care provided by DVA staff in off-site facilities such as veterans' homes are billed. Yet, the services provided include hospital based home care which is often covered by health insurance. These services are also those most likely to expand as alternatives to bed care are encouraged by payor reimbursement rates.

Excluded costs in the miscellaneous benefits and services accounts total $463 million. These include $135 million in District and Regional support, $32 million in Continuing Education Field Units, and $69 million in other continuing education expenses. These costs are as integral to medical center operations as other indirect costs included in rate calculations.

Miscellaneous costs also include approximately $100 million in beneficiary travel costs. This includes payments for ambulances and wheelchair vans. These are costs of doing business because the location of DVA medical facilities often require distant travel by veterans. As such, they should be included in rate computations.

Recommendation #20 - Improvements are needed in rate setting computations to include more expenses in the 'all inclusive' rate. Among the suggestions offered by the Task Force are:

a. Resource Management should establish a separate CDR account for 'big ticket' prosthetics appliances costing $500 or more. These items should continue to be billed on an actual cost basis. Other prosthetic costs including salaries, repairs, and small appliances should be re-bundled as part of the all inclusive per diem or visit rate. The importance of this recommendation will increase if billing for SC veterans treated for NSC conditions is legislated.

b. For billing 'big ticket' prosthetic appliances and non-DVA care services, rate setting officials should develop an overhead factor to be added to actual cost by facility personnel to account for indirect support provided by facility, VHS&RA, Department, or other Government units.

c. Rate setting officials should develop billing rates for home health care and other off-site medical care delivery by DVA staff whose expenses are not now included. This will require cost and workload data to be gathered by billable units.

d. A comprehensive review of expenses distributed to the 6000 series of CDR accounts should be completed. All costs which support the delivery of care including District/Regional support, continuing education, beneficiary travel, and others should be included in the rate structure on a prorata basis similiar to other indirect costs.

Note: If all expenses listed in the above recommendations were included in the billing rates, billings could potentially increase an average of 21 percent.

2. Inappropriate Work Units - The second variable, CDR workload, is also flawed. Ten of the 13 categories of care for which rates are published have patient days as the billable unit. Two problems exist.

The first and most serious is the failure to adjust for projected changes in patient days in the current and budget years. Over the past several years, average daily census and patient days have been declining in DVA medical centers. This trend is consistent with private sector medical centers. Admissions, on the other hand, have increased or remained stable resulting in the same services being delivered over a shorter length of stay. It is likely the patients admitted are sicker than in the past because less serious illnesses are being treated in non-bed settings.

The impact of failing to correct for patient day trends is dramatic. For every 10 percent decline in patient days, an 11 percent understatement of per diem rates occurs; other factors remaining equal. On a collection base of $300 million, the consequence of this deficiency is meaningful.

Recommendation #21 - The Assistant Secretary for Finance and Planning should modify transitional adjustments which bridge past, current and budget fiscal years to include adjustments for workload trends as well as cost. This will improve the accuracy of the workload units, i.e. patient days or visits, used in the denominator of the rate computation. VHS&RA should assist in this effort by budgeting workload in units which correspond to the billing rate structure. These should be coordinated with OMB if necessary.

The second problem relating to workload involves absent bed occupancy (ABO) and pass days. Pass days are days when the patient is absent from his/her bed for less than 96 hours. ABO days arise when absences of more than 96 hours occur. It appears AMIS patient days exclude ABO days, but include pass days. AMIS data is used in creating charge rates. It is unclear whether or not ABO and/or pass days are removed from UB 82 data when bills are rendered. While pass days and ABO days represent less than .5 percent of all patient days, they can represent a billing error of over $1 million annually if the billing units and rate setting computations are not coordinated.

Recommendation #22 - MAS and Resource Management should be tasked with reviewing patient day data in the CDR and MCCR package to determine if absent bed occupancy and pass days have been excluded. If not, they should be removed when computing rates and preparing billings to make them internally consistent.

3. Overhead Factor - The next rate structure deficiency involves the Central Office overhead factor. This adjustment recognizes the prorata support provided by the MAMOE appropriation to medical care. Limiting this adjustment to MAMOE understates intra-DVA support to medical care. Many elements of the GOE appropriation including General Counsel, District Counsel, Budget and Finance, ODM&T, Inspector General, and others contribute to the medical care mission.

It is the Task Force members' understanding that Office of Facilities personnel are capitalized as part of the minor construction appropriation. Since capitalized construction costs are included in rates as building depreciation, these costs need not be considered further. We also understand that marketing center personnel and expenses are included in the marked-up charge for posted stock. If this is correct, these costs would already be included in MCCR rates. Some GOE expenses may already be in the CDR as part of common service expenses transferred to medical care.

Recommendation #23 - Rate setting staff should confer with Resource Management to determine which additional intra-DVA costs should be included in the medical care rates. At a minimum, a prorata portion of GOE should be included.

4. Capital Interest and Unfunded Fringe Benefit Charge - The next category of rate deficiency involves the capital interest and unfunded fringe benefit add-on. The capital interest adjustment presumably accounts for treasury borrowing expenses associated with property, plant and equipment. If this is the case, the capital interest adjustment in the rate setting work papers is puzzling.

In the work papers, the capital interest rate is multiplied times adjusted operating costs rather than unamortized capital costs. This does not seem to have any theoretical basis. Operating expenses associated with billable care would not incur borrowing costs because they would be repaid within the year. The only basis for adding an interest factor for operating expenses would be accounting for interest on working capital.

Unlike other rate deficiencies, this problem tends to overstate rates and makes DVA vulnerable for counterclaims by 3rd parties if they chose to contest rate computations.

Recommendation #24 - Rate setting officials should be requested to clarify adjustments for capital interest which are now applied to operating expenses. If appropriate, they should apply them only to the unamortized portion of plant and equipment costs as suggested in the report. Since most Government real property has been owned for many years, it is unlikely these costs are significant except for more recent purchases of movable equipment.

The fringe benefit adjustment accounts for another cost other Departments and Agencies incur in support of DVA medical care. The Task Force has no information upon which to judge the accuracy of the unfunded fringe benefit adjustment.

5. Malpractice Claims - There is one other expense which is incurred on behalf of medical care by Treasury which is not included in the rate structure. This involves tort claims associated with medical malpractice litigation.

Recommendation #25 - Rate setting officials should include an allowance for tort claims paid on behalf of medical care and charged to the open Treasury appropriation established for that purpose.

6. AMIS Days and Fee Pharmacy - An additional problem which the current rate structure presents has to do with the difference between AMIS and PTF defined bed sections. AMIS records patient days according to the designation of the bed, e.g. medical, surgical, etc. The PTF traditionally records patient days according to the subspecialty of the treating physician. This is a small distinction, but one that can create incongruency between billing rates and patient service units.

One other aspect of the current rate setting structure is confusing. Pharmacy costs for prescriptions written by fee physicians and filled by VA staff have been broken out separately in the rate structure. Since these costs are only applicable to a small number of veterans, primarily service-connected who are on fee basis care, the purpose of breaking out this rate is questioned.

C. Locality and Procedure Specific Rates - The final aspect of rate setting which the Task Force recommends be studied is the appropriateness of the national per diem/visit methodology. Most other providors of care are being paid using case mix methodologies such as HCFA's Prospective Payment System. Even DVA is proposing the adoption of a DRG-based payment structure for contract hospital care.

1. National Rate Structure - The current national rate structure is problematical because it fails to recognize variations in DVA health care costs due to local market conditons. By using a national average rate, DVA providors in extremely high or low cost areas are not billing reasonable and customary charges. Payors in low cost areas can deny payment to the extent DVA rates are in excess of local charges.

The second problem involves billings for outpatient care. It is possible outpatient revenues could be increased by unbundling high cost procedures such as CT scans, radiotherapy, etc. from the all-inclusive rate and billing these separately.

There are other reasons why DVA should investigate the costs/benefits of alternative rate methodologies including:

o DVA lengths of stay tend to be longer than private sector medical centers. Episodes of care in the private sector are for discrete problems. Private sector hospitals, for example, discharge and readmit patients when care is split between an acute and exempt hospital units under the Prospective Payment System. On the other hand, DVA medical centers will have one long, continuous episode of care. This can work against VA medical centers when seeking payment since payors may truncate payment after a certain number of days of care.

o If legislation is authorized to return some of the funds collected to medical centers as incentives, the use of a national average rate structure will be unfair to those medical centers in high rate areas or who bill for more complicated cases.

There are several alternatives for addressing this issue. Rates could be contructed by geographical area. This would lead to more representative rates for high and low cost areas. Case mix methodology using DRG's, RUG-II's, or other case mix adjusted workload could be used. All inclusive per diem and visit rates could be further subdivided to allow for separate billing of high cost procedures, tests or therapies.

Recommendation #26 - The Boston Development Center, DMMS Project Team, and Region I's Management Science Center have all been involved with different aspects of this issue. They have the combined expertise to investigate the benefits of alternative rate methodologies. The Task Force recommends a subgroup be designated composed of representatives from these organizations and Budget Service to evaluate the costs versus benefits of adopting an alternative rate methodology.

2. Patient-Specific Billing - In analyzing the rate structure the Task Force found no evidence the accuracy of billing rates is checked after the fiscal year closes to see if large variances exist. Dan Cameron, a member of the Task Force, compared the published rates with actual costs for fiscal years 1988 and 1989. The following error rates were found to exist:

	------ FY 1988 ------		------ FY 1989 --------	
Type of Care	Over/(Under) Billed	Percent Error	Over/(Under) Billed	Percent Error
Medical	$ 1.35	.3%	$(39.21)	(7.5%)
Surgery	(41.87)	(6.4%)	47.59	7.5%
Psychiatry	2.22	.1%	(14.19)	(5.6%)
Outpatient	18.25	10.3%	(6.26)	(5.4%)
Prescpritions	(1.09)	(7.2%)	(0.91)	(5.5%)

As can be seen by the data, 4 of 5 rates in FY89 were understated. We believe the primary contributor to this error is the failure to adjust for workload changes in the rate computation. Budget Service should annually examine the difference between computed rates and actual costs as a quality control check of their computations.

As mentioned earlier in this report, a legislative initiative for FY91 would extend billing authority to insurers of SC patients treated for NSC conditions. In its present form, the billing rate structure does not permit medical centers to bill on a patient-specific basis. Likewise, there is no provision for billing portions of an episode of care, e.g. particular clinics, etc. when a patient is treated for both SC and NSC conditions.

The latter and many other issues presented in the last section of this report would be helped by accelerating the introduction of DMMS. Using DMMS, medical centers would be capable of rendering detailed patient bills. The improvements in collections could potentially underwrite some of the cost of DMMS to the extent it improved collection rates.

Recommendation #27 - Accelerate the introduction of DMMS. Consider piloting a detailed patient billing using DMMS facility-level charges. If collections can be improved by using the capability of DMMS, consider underwriting part of its cost with MCCR collections.

XI. ORGANIZATION

This subject presented some of the most complicated discussions for the Task Force. The ownership of the billing and collection program and organization to service it were especially problematical.

A. Organization of Billing and Collection Activities - Something which distinquishes DVA medical centers from their private sector counterparts is Medical Administration Service. Few private sector hospitals have an organization comparable to MAS. Billing, financial counseling, and fee basis functions would normally be assigned to the Chief Financial Officer. Admissions, medical records, and ward administration would normally report to the director of nursing or an administrative vice president.

MAS employees have traditionally developed more expertise in medical records, admission screening, patient privacy, release of information, and other activities which relate to billing. People familiar with patient accounts management know the front end of the process is most important. That is to say, the identification of billable cases, the proper conduct of pre-certification and UR functions, the verification of insurance, and presentation of accurate bills are activities more likely to result in greater collections than the more ministerial activities occurring afterwards.

Suggestions have been made to centralize all billing and collection functions under one supervisor. Since there are various skills involved in MCCR activities including MAS, Nursing, IRM, and Fiscal, placing them under one organizational unit is a problem. Additionally, there is the matter of personnel who work only part time on MCCR activities with other time devoted to unrelated activities. Space and location issues also complicate the issue.

Recognizing these factors, the Task Force believes Facility Directors should continue to organize the billing and collection functions as they deem best. The Task Force has seen no evidence that centralizing the billing and collection function produces better collection outcomes although it logically follows that centralization may be best.

The more likely ingredient for a successful program is a strong personal commitment by one or more members of the top management triad. Many Associate Directors hold regular meetings with MAS, Fiscal, and other elements of the organization to discuss progress in meeting third party collection goals.

Successful programs are also characterized by positive and close working relationships among employees involved in registration, billing, collection, and utilization review. This may be done through some form of matrix organization, designation of a program coordinator, or consolidation of some functions under a single manager as is the case in private sector hospitals.

Mandating a change, however, may injure already well functioning programs. Where MCCR billing and collection results are poor action is required.

Many MCCR functional, programmatic and operational activities are traditionally associated with MAS. These include identification of beneficiaries with insurance, release of information, ICD-9-CM coding, medical records administration, reception activities, public relations, legal eligibility determinations, patient registration, correspondence, and billing. Fiscal Service traditionally dispatches bill to the payor and maintains collection activities.

Facility directors should take positive steps to rectify poorly functioning medical care cost recovery (MCCR) activities by closely scrutinizing their organizational structure. Existing organizations with MCCR tasks assigned as collateral duties may be compromising their cost recovery programs. In addition, organizational elements which are characterized by high turnover are vulnerable.

If facility directors identify deficiencies in the organizational structure, immediate action should be taken to centralize activities into a functional unit which only has MCCR duties assigned.

Regardless of the organizational structure, accountability should be clearly fixed.

> *Recommendation #28 - Continue authority for local facility Directors to internally organize billing and collection functions as the local situation dictates. Encourage realignment of functions or duties into a centralized unit where needed and effective.*

B. Functional Statements - VACO officials can assist facility managers by clearly delineating policies and procedures on billing and collection functions. This will encourage local

officials to prepare well-developed functional and position statements. The salary and other expenses associated with each of these functions should be chargeable to the new appropriation proposed in the FY91 budget, if approved. Billing and collection functions include:

o Pre-admission activities - Complying with admission pre-certification, 2nd surgical opinion, and other carrier requirements.

o Admission process - Screening patients for means test status, insurance coverage, and eligibility.

o Insurance Verification - Reviewing insurance coverage to determine if the care is covered, the policy is still in effect, and utilization review/pre-certification requirements are identified.

o Billing - Extracting data from the clinical record to complete the UB-82 and supporting documents.

o Accounting and Voucher Audit - Recording the claim as an accounts receivable.

o Billing Follow-up - Making contact with the carrier to resolve questions and provide additional documentation so the claim will be expeditiously processed.

o Collection - Submitting demand letters, undertaking legal action to collect amounts due, and processing adjustments or termination action for amounts no longer due.

o Cashiering - Collecting payments.

o Account Posting - Posting collections and adjusting billings when appropriate.

o Account Resolution - Verifying that reasons for payment denial are valid.

The Task Force believes each medical center should consider the appointment of a billing and collection coordinator. This is especially important if functions are not under one supervisor. This person could be the Associate Director or other person in a position to operate in a matrix fashion to insure collection targets are achieved.

A typical private sector patient accounts organization is attached for reference and information.

Recommendation #29 - Require medical centers to designate a MCCR Coordinator similar to RMEC and AMIS liaison Officials. Insure that Resource Management includes in the definition of CDR account 6016, Billing and Collection, costs for each of the above functions.

C. National Program Management - Nationally, MCCR-related billing and collection activities are managed or significantly influenced through a variety of organizations. They include:

o MAS - Issues policy and procedures related to billings, eligibility determinations, medical records, administrative admissions screening, and similiar functions.

o General Counsel - Provides advice and support on legislation, litigation, contracts, and other matters relating to billings and collections.

o Finance - Issues policy and procedures related to collections including follow-up letters, terminations, suspensions, and referrals.

o Budget - Prepares new rates and budget estimates.

These are the major program offices currently involved in the billing and collection function. Other program offices such as Resource Management are involved to a lessor degree.

Organizing these diverse skills under one supervisor does not seem any more feasible on a VACO level than on a facility level. There is a need, however, for a knowledgeable VACO manager who can coordinate the effort. In other words, a manager needs to be assigned who can be held responsible for the coordination of training, legal assistance, budget review, collection policy, billing procedures, and all other activities which impact on the MCCR program...eventhough he/she would be relying on other programs within VACO for support.

Because of the importance of MCCR activities and special managerial skills demanded by a matrix-style organization, the incumbent should be a high-level manager.

> ***Recommendation #30 - Appoint a VHS&RA Manager of MCCR Billing and Collection activities who would coordinate the efforts of the various VACO elements supporting the program. This manager would also serve as the contact point for field-based MCCR Coordinators.***

Since a basic management tenet is to couple program responsibility with program authority, it is important this function be closely aligned to line management. If it is not, the responsibility for collections should migrate to the office which has the predominate authority for developing billing and collection policy.

In the DVA Congressional Budget Submission for FY91, the role of the DVA Chief Financial Officer (CFO) insofar as debt collection was specified. It said:

> "...he will provide the policy direction for the program. The CFO will facilitate the implementation of third party collection activities in all facilities by coordinating the development of uniform procedures and training, by providing the catalyst for system changes and enhancements, and by working with VSH&RA to develop a positive incentive program. The CFO will also manage the special resource account for the program and will perform oversight responsibilities focusing on program performance, effectiveness, timeliness, accountability, etc.
>
> The CMD will maintain his line operational control over the billing and collection activity in the facilities. He will also continue to be responsible for the successful day to day operations of this activity, as he currently does, through his regional directors and his facility directors. Finally, the CMD will work closely with the CFO to identify additional program modifications or enhancements which may lead to increased collections."

The FY91 budget submission also included a major initiative to implement an enhanced Third Party Reimbursement program with responsibility under the direction of the CFO. The initiative has two facets. In central office, a staff will develop nationwide and individual field station annual dollar goals; and develop information, guidelines and procedures to veterans, insurance companies, and field staff to ensure an effective collection program. The staff will also help develop legislation and manage the new fund.

Additionally, a field station fiscal quality assurance activity will be established at the VA Finance Center in Austin, Texas. This group will visit field stations to insure compliance with policy. Total resources requested by this Office for the Third-Party program are 18 FTEE and $1.4 million.

Members of the Task Force suggest having the compliance group develop more of an 'assistance role' rather than an 'audit role' when visiting field stations. Field personnel are already laboring to conduct a program for which few, if any, resources were provided. Funding a compliance staff which does little more than tell facility personnel they are per-

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forming poorly may create more ill-feeling than improvement.

> ***Recommendation #31 - Orient the mission of the proposed financial quality assurance group towards 'assistance' rather than 'auditing'. The Task Force believes this will have a more positive impact on medical center financial operations.***

D. MCCR-Related Position Classifications - There is no precedent within the Government for activities similiar to MCCR. Unlike other debt collection, MCCR collections involve claims against insurers and patients. Claims do not have the same force of law as do commercial debts. Billing and collection operations for medical services require VA personnel to have knowledge of medical terminology, health insurance coverage, billing rates, pre-certification requirements, and other items.

When MCCR activities were limited to humanitarian, tort feasor, no fault, crimes of personal violence, ineligibles and workman's compensation, the program was quite small and demanded fewer skills. Passback estimates predict collections will be close to $1 billion by FY95. This significantly changes the nature of the MCCR program.

A complete evaluation of the skills, grade levels, and duties of positions involved in MCCR-related activities needs to be made. The Task Force believes this is best performed by an outside contractor. This type of analysis has been done for other functions within VA including ADP and Nursing.

> *Recommendation #32 - Commission a private consulting study to evaluate the appropriateness of the current functional alignment and position classification structure necessary to properly manage a patient accounts program estimated to grow to $1 billion in 5 years.*

E. MCCR Advisory Group - The charter for this Task Force will expire on April 30, 1990. It has served a useful purpose by bringing together field and VACO program officials from various disciplines including Line Management, Quality Assurance, Finance, MAS, General Counsel and IRM for the purpose of improving billing and collection. The Task Force believes some permanent organization of this type would be useful.

A combined VACO and field-based advisory group would overcome many problems traditionally encountered in managing programs with multiple specialties. For example, relying on existing advisory groups such as the Fiscal Officers' Advisory Group fails to provide a balanced representation of problems, needs, and recommendations.

> *Recommendation #33 - Upon dissolution of the MCCR Task Force, appoint a permanent advisory group which would report to the VHR&RA MCCR Program Coordinator (see earlier recommendation). The advisory group should have VACO and field representation from all major functional areas involved in the MCCR program. At a minimum, this should include representatives from QA, MAS, IRM, General Counsel, VAMC top management and Finance.*

XII. CASH MANAGEMENT

VA's patient accounts management has so far concentrated on the identification of billable patients and garnering cooperation from payors to pay. Private sector medical centers who have been in this business for years are more attuned to the timeliness of payments.

A. Key Statistical Measures - One of the most often watched statistics in private sector hospitals is 'days in net accounts receivable'. This measures the number of days of operating revenue a hospital has in accounts receivable after allowing for contractuals and doubtful accounts.

Although cash management is actively practiced in other DVA financial programs, it is not yet a dominant part of MCCR activity. With program growth expected to reach $1 billion per

year by FY95, a one-day delay in collecting the average bill will result in an interest loss of about one-quarter million dollars. A 30 day delay will cost the Treasury about $8 million.

The Task Force initiated a short study to identify the average processing time from discharge/visit to collection. Data was gathered from 5 medical centers for receivables on which payments were made in February 1990. The study results were as follows:

Processing Step	Average Time in Days
Discharge/visit to billing	64
Billing to mailing	7
Mailing to collection	87
Total Days	158

It should be remembered these were bills for which payments were received. Many other bills were still outstanding or had collection action terminated.

Non-DVA hospitals usually bill within the first week after discharge or visit. The survey indicated DVA facilities bill an average of 64 days after discharge/visit. This delay alone will cost the Treasury over $16 million in interest if collections rise to the $1 billion level. Even at the more conservative annual collection level of $140 million, a 60 day delay will cost nearly $3 million.

The total interest cost if collections are not received until 158 days after discharge/visit will range from $7 to $51 million depending on the annual collections made.

Improvements recommended earlier with regard to data base modifications will permit some of these statistics to be monitored regularly on a national basis.

The February/March 1990 issue of The Journal of Patient Account Management has an excellent article on "Applied Ratio Analysis for the Patient Account Manager". The article, authored by Martin Kofsky, Director of Marketing and Education Insurance Recovery Specialists, Inc., presents several ratios which could be used to monitor hospital performance in billing and collection functions.

Recommendation #34 - The VACO MCCR Billing and Collection Coordinator should develop statistics such as days in net accounts receivable comparable to private sector hospitals for monitoring the promptness with which payments are made. These statistics should, in part, form the basis of performance award criteria. Periodically, a survey should be conducted of randomly selected receivables to identify bottlenecks which may be occurring in billing, UR, accounting or other activities which process AR's.

B. Enforcement of Collection Standards - DVA patient accounts managers face somewhat unique circumstances in collecting medical claims. First, patients cannot be billed for the uninsured portion of medical care costs. The patient, therefore, cannot be used as an effective lever in getting their insurance company to act.

Second, patients cannot be denied treatment because they refuse to provide information on insurance coverage or pay deductibles or copayments.

Lastly, many third party payors have been uncooperative in paying VA medical claims. Some, such as Medigap insurers, have cooperated only after threat of litigation. The DVA and other health care providors are in distinctly unfavorable positions when payors refuse to cooperate. This is because medical claims are not liquidated debt and interest charges on late payments cannot be assessed.

DVA's situation is even worse because we cannot bill the patient for the uninsured portion thereby losing this indirect method of persuading the insurer to pay. In addition, DVA has traditionally not engaged in preferred providor arrangements. Private health care organizations typically use these as a means for expediting payment in return for discounted medical charges. As a consequence, payors can use delaying tactics with DVA and improve their cash management without fear of reprisal.

A careful interpretation of existing law and regulations suggests there may be authority for assessing interest penalties on tardy payors. If this authority could be exercised in a manner similar to the interest charged under the Prompt Payment Act, the number and timeliness of MCCR collections could substantially improve.

Exercising such authority, if it exists, should be done prudently so as not to create an administrative 'nightmare'. Limiting penalties to bills over 'X' dollars may be one approach.

> ***Recommendation #35 - DVA should exercise whatever authority currently exists for selectively imposing interest penalties on unwilling and tardy payors. Should authority not exist, DVA should consider introducing legislation which would impose an interest penalty or similar sanction on selective payors who repeatedly fail to pay properly submitted billings within 30 days of receipt.***

C. Interim Billings - Some VAMCs, especially those with large psychiatric patient workloads, have lengths of stay well in excess of 30 days. Only some VAMCs issue interim billings eventhough patient stays may exceed 30 days. This defers cash collections and incurs higher interest cost for the Treasury. When patients are likely to be hospitalized for long periods, VAMCs should issue interim billings every 30 calender days.

> ***Recommendation #36 - VAMCs should be encouraged to issue interim billings for long-stay patients every 30 days if a likelihood exists the patient will remain hospitalized for at least 30 more days after each interim billing period arrives.***

D. Special Handling of Receipts - Large medical centers in the private sector rely on lock boxes to reduce the time between remittance of payments and deposit credit at their financial institution. Lock boxes are used at Austin Finance for collections. Based on a collection base of $1 billion per year, a one or two day improvement in deposit crediting can save hundreds of thousands in lost interest. The use of lock boxes may be economical only at large VAMCs or those which can arrange to joint venture with other VAMCs.

Past experiments with lock boxes in the DVA have met with mixed success. They usually require a high level of automation for feedback of deposit information that may not be within the capabilities of most VAMCs. They would also require some form of payment identification or payment card system to be used with remittances which may not currently exist.

E. Timeliness of Claims - One of the most important variables in collection activity is timeliness of billings. Collection experts readily agree the older the claim, the less likely collection will occur. For this reason, VAMCs should be encouraged to give priority handling to patient records which involve billable cases. This is especially important for inpatient services which involve more money. Techniques such as tagging patient records of billable cases should be considered.

A matrix of follow-up actions which specifies actions appropriate to different claim amounts should be published. For example, claims involving $10,000 or more should be followed up with phone calls; not just a standard follow-up letter. As a general rule, phone contacts should be encouraged over form letter correspondence.

F. Electronic Billing - Many private hospitals are taking advantage of electronic billing by submitting claims directly to payors or through clearinghouses. VAMCs Richmond, Salem and Hampton are currently experimenting with this technique. Initial results are quite encouraging with payments generally made within one week. DVA should continue to investigate the cost versus benefits of electronic billing through development of in-house service bureaus or by contracting with commercial firms. This capability should be incorporated in enhancements added to the IFCAP A/R package.

G. Credit Card Collections - When collecting 1st party, i.e. means test deductibles and copayments (if legislated), patients should be encouraged to pay by credit card or cash prior to leaving the facility. In fact, consideration should be given to locating credit card processing devices in the outpatient area so collections can be made prior to treatment.

> ***Recommendation #37 - The VHS&RA MCCR Coordinator should ensure positive results of pilot activities on electronic billing are fully exploited. Other techniques such as the use of lock boxes, special handling of billable case records, decision rules on claims follow-up, and others are tested and encouraged where appropriate. Encourage VAMCs to use credit card devices in patient registration areas so deductibles and copayments can be collected prior to treatment for category B and C veterans.***

XIII. MANAGED CARE PLANS

Managed care plans integrate financing mechanisms, appropriate utilization management, and high-quality service delivery. They 'manage' by controlling the selection and use of services and provide appropriate benefits coverage. HMOs (Health Maintenance Organizations), CMPs (Competitive Medical Plans), PPOs (Preferred Providor Organizations), and direct agreements between employers and providors are among types of managed care plans in existence.

As of December 1988, approximately 32 million people in the United States, or 12.9 percent of the total population, were enrolled in HMOs or similar pre-paid health plans. HMOs require subscribers to use certain providors after obtaining approval from the HMO primary care physician, i.e. 'gatekeeper'. Only in emergency or urgent care situations can non-participating subscribers be reimbursed by the HMO. Since DVA medical centers have not entered participating providor contracts with HMOs, they seldom obtain reimbursement.

Another type of managed care plan which is growing even faster than HMOs are PPOs. PPOs are delivery systems or contractual agreements between a providor and third party payor. The providor agrees to deliver services to a specific group of subscribers, usually on a discounted fee-for-service basis. Subscribors are generally employees of a firm and are given financial incentives such as reduced copayments to use the providor. Subscribers reserve the right to use other providors. The providor is usually guaranteed a large pool of potential payments and rapid payment.

As of December 1988, there were 680 operational PPOs in the United States, and more than 34 million individuals were insured by plans with a PPO option. Collectively, HMOs and PPOs now insure nearly 30 percent of the U.S. population.

Unfortunately, DVA medical centers seldom become involved in PPO agreements. They also do not have the authority to negotiate prices in return for faster payment as do non-DVA medical centers. Non-DVA medical centers usually discount charges in return for faster payment. Since charges may be well above actual costs, non-DVA medical centers have substantial leverage in discounting charges when entering PPO agreements.

DVA charges are based on average costs. Consequently, they do not offer the same opportunities for discounting available to non-DVA hospitals. This notwithstanding a DVA medical center may well find itself in a position to offer rates lower than published national DVA rates and still be able to cover its marginal costs.

HMOs and other managed care programs represent a growing segment of the payor base. Unless DVA can find a better method for relating to these plans, it may be shut out from an expanding source of 3rd party reimbursements.

Recommendation #38 - VHS&RA should pilot a small number of managed care agreements to develop more expertise in this area. Pilots should include HMO and PPO agreements. These pilots could also determine if collections can be increased or accelerated through the use of managed care arrangements. DVA should consider obtaining authority for two or three medical centers to negotiate prices locally as long as the marginal cost of additional caseload is covered. Initially, managed care agreements should be restricted to veteran patients.

XIV. PRIVACY ACT RESTRICTIONS

Treatment information on several types of DVA care cannot be released to third parties without the consent of the patient. These include alcohol, drug, HIV, and sickle cell treatment. Third parties usually will not reimburse without this information. Since these workloads are among those growing fastest, VAMCs may be prevented from collecting a large portion of third party reimbursements.

General Counsel has encouraged District Counsels to pursue court authority to release information on these cases when bills are in excess of $25,000. Medical Centers should be reminded of this policy and encouraged to work closely with their District Counsel when applicable cases arise.

XV. RESOURCE ALLOCATION FORMULAE

The Resource Allocation Model (RAM) and Equity of Access adjustment have been used by VHS&RA to distribute funds among medical centers. Several times the Task Force encountered situations where one or both of these allocation methods may be hurting third party collection.

For example, Equity of Access penalizes medical centers who treat high proportions of Category 'B' and 'C' veterans. This naturally reduces the number of these veterans and 1st party copayments which they produce. Additionally, the Survey of Medical Systems Users (SMSU) conducted in 1988 shows that Category 'C' veterans are over 3 times more likely to have commercial health insurance than Category 'A' NSC veterans. The survey indicated 51 percent of Category 'C' vets carry private health insurance versus only 15 percent of Category 'A' NSC vets.

RAM also presents difficulties in managing third party reimbursements because it tends to encourage admissions for some types of care which third parties reimburse only on an ambulatory basis.

Recommendation #39 - Developers of resource allocation methodology should consider the financial impact likely to occur on third party reimbursements. If a new methodology is likely to decrease reimbursements, VHS&RA's collection target should be modified accordingly or the methodology should be adjusted to remove disincentives.

XVI. IMPACT ON THE VETERAN

The 'charge' letter requested the Task Force to comment on the impact which recommendations would have on the veteran.

On the positive side, higher reimbursements are likely to result in more budget authority for medical care. This will permit the continuation and possibly expansion of services, improve-

ments in quality, and other benefits generally realized when more resources are available.

On the negative side, a greater emphasis on third party insurance could tend to increase insurance rates for some veterans especially those enrolled in small group plans. There has been some indication that veterans have refused to provide insurance information because they fear the employee association health plan rate to which they belong will increase.

It is known that insurance providors are becoming more aggressive providing risk-adjusted rates to employers. During a meeting of the Task Force, the president of a Blue Cross affiliate was asked about the potential impact on a veteran's health care coverage if his employer's plan was heavily billed for DVA care. He indicated that an insurer of a small business with 25 or fewer employees would likely have rate increases of 100 percent or more if health costs substantially increased for one of its employees. The alternative for the business would be to drop coverage on the high risk employee.

While reports by GAO, CBO and others may indicate that billing third party carriers for DVA care will have no impact on the 'average' veteran, the impact on some veterans may be quite severe.

Another negative effect on veterans could occur if cost plus reimbursement incentives are some day legislated. Medical centers may gravitate toward selection processes or treatment patterns which favor veterans with health insurance coverage. While we hope this may not happen, budget shortages may foster this tendency.

As MCCR activities grow and more types of care are made billable, VA should be watchful in ensuring delivery patterns do not become commercialized at the expense of entitled or needy veterans.

> *Recommendation #40 - Task an HSR&D or other qualified group to perform a multi-year study to determine if health insurance premiums for veterans subject to third party insurance reimbursements increase more or at the same rate as other veterans or the population as a whole especially for those working in small businesses. If cost-plus incentives are legislated, maintain a continuous monitor of indicators which would warn if adverse selection processes are being introduced.*

XVII. RESOURCE REQUIREMENTS

The Task Force was also asked to estimate the resource requirements necessary to carry out its charge and its recommendations.

Many of the actions proposed would be funded from the $2 million in medical care funds set-aside in FY90. As recommended throughout the report, the Task Force believes all costs incurred as a result of billing and collection activities should be charged to collections. If a separate appropriation is approved in FY91, the statutory language should support all-inclusive charges.

In an attempt to quantify the resources necessary to support the recommendations contained in this report, a budget has been prepared and is attached.

XVIII. DOD COLLABORATION

Approximately the same time DVA was extended authority to collect from third party insurers, DOD was given similar authority. DOD bills for care provided through uniformed services health care facilities as well as care delivered by CHAMPUS providers when patients have third party insurance.

There are a number of common areas shared between the DOD and DVA third party billing

programs. This presents several opportunities for joint sharing of ideas, training, and other programs.

To encourage this, the Chairman presented the preliminary results of the Task Force at the 'Federal' session of the American College of Health Care Executives. The Task Force also invited members of DOD to the final meeting of the Task Force in April.

At the April meeting of the Task Force, Lt.Col. Paul Kearns presented a briefing on DOD's third party collection program. Many of the problems and solutions which DOD has identified are the same as with DVA.

> *Recommendation #41 - The continued sharing of ideas and efforts between DOD and DVA in the medical care cost recovery program should be encouraged by regular meetings and allowing DOD representatives to participate in MCCR conference calls and e-mail groups. DOD and DVA should designate liaison persons who will be responsible for encouraging sharing of ideas within the third party insurance program.*

STATEMENT OF

CLINT G. GARDNER
BIRCH & DAVIS ASSOCIATES, INC.

BEFORE THE
SUBCOMMITTEE ON HOSPITALS AND
HEALTH CARE OF THE
HOUSE COMMITTEE ON VETERANS AFFAIRS

June 20, 1990

Thank you for the opportunity to present some findings about collection of third-party medical accounts receivable in the Department of Veterans Affairs. I hope that the material I present today will help illustrate and confirm the magnitude of the DVA's opportunity for third-party collections.

I also hope that this material will stress the need for a more comprehensive billing and collections program that can ensure that more of the dollars owed to the DVA are collected.

In April of 1988 my employer, Birch & Davis Associates, Inc. (B&D), was engaged by the Richmond, Virginia, VAMC to study its billing and collections operations. Our study came only 18 months after passage of PL 99-272. This law both permitted and required that VAMCs collect private third-party payments on behalf of Non-Service-Connected (NSC) Veterans who have private health insurance policies.

Since then, B&D has conducted site visits to six other VAMCs to study billing and collections potential. We have made presentations to DVA field and central office staff about the DVA's collection opportunity. We also have researched many of the legal, financial, and technical issues related to developing a program to help the DVA to maximize collections.

B&D has also reviewed billing and collections opportunities at five Department of Defense hospitals. Our findings at DoD hospitals closely parallel findings at VAMCs.

Our initial study found that the Richmond VAMC was billing for only a fraction of the dollars due it from private third-party insurance companies, and from other sources. Further, only a fraction of the dollars billed were actually collected.

In a 12-month period just prior to our study, the Richmond VAMC had billed $5.9 million, and collected $1.07 million. This is a collection rate of 18 percent.

We concluded that the VAMC could have billed approximately $15.2 million and collected $11.4 million. The Richmond VAMC was, then, collecting less than one of every ten dollars that could have been collected.

The actions necessary to increase collections at Richmond more than ten-fold were and remain permissible under the laws and regulations that govern VAMCs. None of these actions would harm or restrict the VAMC's health care mission in any way. These dollars could be collected without change to any laws or regulations, and without encumbering the VAMC's mission.

Over 70 percent of the available but uncollected dollars at the Richmond VAMC were related to the fact that insurance coverage was not identified and insurance bills were not produced:

- First, the VAMC had not identified inpatient insurance coverage in many cases. Had coverage been identified for all NSC Veterans having private insurance coverage, the VAMC could have billed $4.4 million more than it actually billed.

- Second, the VAMC did not produce bills for NSC Veteran inpatients who were known by it to have private insurance coverage. Had bills been prepared for all inpatient care that was known by the VAMC to be covered by private insurance, the VAMC could have billed $1.6 million more than it did.

- Third, the VAMC did not have equipment or resources sufficient to bill for outpatient care. Had these systems been in place, the VAMC could have billed $1.25 million more than it did that year.

There is, then, a significant difference between the amounts of premium payments made by Veterans and their civilian employers to private insurance companies, and the amounts of claims paid by insurance companies to cover medical care for these same Veterans.

In effect, the premium payments made by Veterans and their employers provide a subsidy to non-Veteran insurance beneficiaries.

As long as the DVA does not collect these dollars this inequity will exist. Yet, there are no technical or operational impediments preventing the DVA from collecting the third-party funds owed to it.

The magnitude of the DVA's opportunity to collect third-party revenue is a simple function of the number of NSC Veterans having private insurance coverage.

Expert opinions vary considerably about the numbers of NSC Veterans having private health insurance coverage. All estimates, however, demonstrate that a significant number of Veterans do have coverage:

- The 1979 DVA Survey of Veterans (SOV) estimated that 38.2 percent of all Veterans had private insurance coverage.

- A 1985 GAO report found that 18 percent of NSC Veterans had current and applicable insurance at the time of their last VAMC contact, but that only 6 percent advised the DVA that they had such coverage.

- The 1987 DVA Survey of Veterans (SOV) estimated that 86.6 percent of all Veterans had private insurance coverage. Coverage ranges from 96 percent for Category C Veterans, to 64 percent for Veterans with income of $10,000 or less.

- A 1989 Paralyzed Veterans Association (PVA) report estimated insurance coverage from 68 to 76 percent for Veterans with income of $15,000 or less. These figures are from DVA Districts 2, 12, 17, and 24.

- The DVA's Medical Care Cost Recovery (MCCR) Task Force's November 13, 1989, report, *An Analysis of Third Party Reimbursement Activities within the VHS&RA*, estimated that inpatient insurance coverage among NSC Veterans ranged from 18 to 59 percent. Medicare supplement insurance was estimated at between 11 and 56 percent. Coverage for outpatient care ranged from 22 to 46 percent.

Interestingly, the 1985 GAO report also found that 89 percent of Veterans did not "object to VA recovering a portion of the cost of their non-service-connected care from their insurance company, if there were no cost to them for their episode of care."

We are aware of five studies, in addition to our own, that estimate the DVA's total third-party insurance potential. All were conducted within the last 10 years. Although these studies used different data, different methodologies, different definitions, and studied different time periods, all concluded that significant amounts of dollars went unidentified and uncollected.

Dr. Holzinger's 1981 master's thesis, *The Cost of Reimbursing the Veterans Administration for Health Care*, estimated that $596 million could be collected from private insurance companies by the DVA. If DVA administrative costs are included, Dr. Holzinger estimated that $612 million would be shifted from the Federal Government to the insurance industry. A 1982 Facilities Planning and Construction Committee (FPACC) study commissioned by then VA Administrator Robert Nimmo mentioned the need for the DVA to collect private insurance dollars rightly owed it. Recently, I contacted the director of that study, Dr. O. David West. He estimated that, based on study findings from 1982, as much as $2 billion per year may now be available to the DVA.

A 1985 study conducted by then VA Administrator Harry Walters projected that reimbursements from insurance companies alone would total $831 million in FY 1989. Administrator Walter's estimate does not include other payer sources (i.e., tort feasor, co-pay, and sharing agreements).

GAO's April 1990 study, *Better Procedures Needed to Maximize Collections From Health Insurers*, estimates collections from private health insurance on behalf of NSC Veterans at between $55 million and $392 million per year. GAO's most likely estimate is $223 million per year. The GAO's estimate does not include other payer sources (i.e., tort feasor, co-pay, and sharing agreements).

The DVA's Medical Care Cost Recovery Task Force's November 13, 1989, report, *An Analysis of Third Party Reimbursement Activities within the VHS&RA*, estimates collections from private health insurance companies on behalf of NSC Veterans from a low of $325 million to a high of $745 million per year. The MCCR's "middle estimate" is $535 million per year. This study also notes that the "patient accounts program (is) estimated to grow to $1 billion in 5 years."

If B&D findings from the Richmond VAMC are applied to the rest of the country, they suggest that at least $552 million are available annually to the DVA (from all payer sources).

Averaged, these studies suggest that the DVA can collect about $796 million per year. To add perspective, these studies mean:

- The DVA could collect an average of $4.6 million every year for each of its 172 hospitals.

- The DVA could collect $3.06 million for every working day in the year.

- The DVA could collect $2,364 for each of the NSC Veterans who annually seek DVA health care.

- The DVA could collect $7.9 billion over 10 years by instituting an effective billing and collections program.

I believe that three factors (if not remedied) will continue to prevent the DVA from realizing its revenue potential from private insurance companies:

- **First**--There are strong disincentives preventing VAMCs from devoting resources to third-party collections. CFR 38 requires that all insurance reimbursements collected by the DVA be deposited directly to the general fund of the Treasury. Regardless of the amount of resources expended, or the effectiveness of collections efforts, no direct benefit can be derived by a VAMC.

  In fact, billing and collection activities may be the only mandated activities at a VAMC that yield literally no benefit to a VAMC. Billing and collection activities do not increase the VAMC's resources, enhance patient care, or create management information, and do not improve morale.

- **Second**--Current automated accounts receivable systems are not adequate. Billing and collections operations in the DVA are operating without benefit of a sophisticated automated accounts receivable system. In fact, many aspects of billing and collections activities are not automated at all. Front-end claim edits, individual payer databases, automated "paperless" claim submission, automated generation of correspondence, and a variety of other accounts receivable systems capabilities are critical determinants of the effectiveness and efficiency of operations. A billing and collections program can only be as efficient and effective as the processing system upon which it operates. Such systems now are in operation in most private sector health care organizations. Although the DVA is currently developing a software program to facilitate billing and collections, it will be years before this system approaches the functionality of currently available private sector systems.

- **Third**--The average VAMC does not have a sufficient number of billing and collections personnel. Comprehensive billing and collections activities, even in a highly automated hospital setting, require considerably more FTE than are allocated at most VAMCs. For example, one 1,000-bed facility we studied recently had approximately 6 FTEs allocated to billing and collections. We estimated that approximately 35 FTEs would be required to process this hospital's in- and outpatient insurance claims. Given the severe staffing pressures facing VAMCs, a decision to devote additional staff to the no-yield administrative task of billing and collection will not seem logical to most VAMC Directors.

House Resolution (H.R.) 5114 was introduced on July 28, 1988. H.R. 5114 proposed amending CFR 38 to allow the DVA to engage private sector contractors to manage billing and collection operations and to retain a percent of collections. H.R. 5114 did not become law.

Each passing day represents a tremendous lost opportunity for the DVA, for Veterans, and for taxpayers. A program such as the one called for by H.R. 5114 is urgently needed to demonstrate that the DVA can and will capitalize on these billing and collection opportunities, if given sufficient latitude and incentive.

To be successful immediately a billing and collections program should have the following characteristics:

- The program should permit immediate integration of private sector accounts receivable technology, expertise, and resources into the DVA. Private sector skills and assets can be accessed immediately. Integration of private sector skills and assets into the DVA can dramatically reduce the time required for the DVA to realize its collections potential.

- The program should require that contractors be reimbursed only from the collections generated by their efforts. Such an "at-risk" arrangement contains powerful incentives that will foster cost efficiency and maximize revenue. At-risk incentives will also make contractor operations largely self-managing. Reimbursing contractors only from collection proceeds means that the DVA will incur virtually no other program costs. In effect, private sector skills and assets can be used free of charge by the DVA.

- The program must allow a significant portion of the monies collected to be kept by the DVA and by individual VAMCs as discretionary income.

- The program must provide assurances that the DVA's budget will not be reduced dollar for dollar by the amount of reimbursements retained by the DVA.

Identifying and processing insurance billing information is a complex job that consumes a significant amount of resources at most private sector health care organizations. The tasks that comprise overall billing, collections, and accounts receivable management operations are, however, accomplished routinely and effectively by these organizations.

Unlike the private sector, the DVA does not (and should not) rely on insurance collections to cover the cost of medical care. Since October 1986, the DVA has been charged with identifying and recouping insurance collections, yet it has not assembled the resources to accomplish this task.

In the final analysis, the medical claims owed the DVA are legitimate, irrefutable claims by the Federal Government against large, often national, insurance companies. There is no reason these dollars should not be collected.

The DVA can collect these monies if, and only if, they have access to the resources, operational latitude, and financial incentives that are prerequisite for success in the private sector arena of third-party claims processing and collection.

I have taken the liberty of including a brief overview of a plan that I believe contains the key elements of such a program. It is attached as Appendix A. Thank you for the opportunity to share this information. I would be happy to answer any questions you have.

APPENDIX A

OVERVIEW OF A PUBLIC/PRIVATE PROGRAM TO MAXIMIZE BILLING AND COLLECTIONS IN THE DVA

APPENDIX A(1)

OVERVIEW OF A PUBLIC/PRIVATE PROGRAM TO MAXIMIZE BILLING AND COLLECTIONS IN THE DVA

A program for collection of third-party insurance claims should call for a private contractor to place trained, skilled, highly motivated staff at VAMCs throughout the country. These staff would possess the latest in accounts receivable equipment and technology, would be responsible for all processing and collections operations, and could be provided at no cost to the Government.

The program cannot focus only on collections. It must encompass three major operations of the billing and collections cycle:

- **Admissions**--which includes initial patient contact (for some patients) financial status assessment, determination of insurance coverage, and gathering all other data required for bill processing
- **Processing**--which includes compiling data, determining fees, and generating and distributing bills
- **Collections**--which includes receipt of payment, accounting for and reporting on receipts, and a variety of follow-up activities

Under a public/private partnership, DVA staff will continue to be responsible for all admissions (patient contact) functions.

Contractor staff would be charged with ensuring that:

- Each admission, outpatient visit, or other medical service that could result in a billing opportunity for the facility is identified.
- Each of these services does, in fact, result in a bill being generated and sent.
- All communications with insurance companies and other payers are conducted in the fastest and most economical manner possible--much of the communication currently being done by mail in the DVA could be done by electronic transmission, greatly reducing the time for initial billing, routine correspondence, and clarification or requests for addition information.
- All administrative procedures related to the collection of accounts are managed in a timely and thorough fashion.
- All administrative procedures related to follow-up for overdue or delinquent accounts are managed in a timely and thorough fashion.
- Medical accounts receivable are tracked, aged, analyzed, audited, and reported upon in a fashion that will allow logical and cost-benefit-based action for each individual account.
- Medical accounts receivable that are determined to be uncollectible through administrative procedures are promptly identified, and referred to the correct government collection authority.
- All data processing operations are conducted along generally accepted industry standards for data processing, data security, patient privacy, and physical safety.

Processing operations could be supported by currently available hardware and software. From three to ten terminals could be located strategically in patient and information flow paths in the VAMC. Both DVA and contractor staff would have access to computer terminals.

Initial operations would rely on paper source documents generated by DVA admissions staff as input to the contractor's billing and collections system. This stop-gap approach should be phased out as quickly as possible, and be replaced by a computer interface.

Once developed, the interface will permit automated exchange of data between the systems.

All project activities, including home-office management, overhead costs, general and administrative costs, reporting, and on-site staffing at government facilities could be paid for solely from the proceeds of these billing and collections operations.

No other allocated or appropriated DVA funds would be required to further support a public private partnership billing and collections program.

STATEMENT OF

JAMES N. MAGILL, DIRECTOR
NATIONAL LEGISLATIVE SERVICE
VETERANS OF FOREIGN WARS OF THE UNITED STATES

BEFORE THE

SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES

WITH RESPECT TO

H.R. 4935, "MEDICAL CARE COST RECOVERY AMENDMENTS OF 1990"

WASHINGTON, D. C. JUNE 20, 1990

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

On behalf of the 2.8 million members of the Veterans of Foreign Wars of the United States and its Ladies Auxiliary, I wish to thank you for having invited the VFW to participate in today's important hearing. We are highly gratified that our voice should be heard in this hearing addressing this important legislative initiative.

H.R. 4935, introduced at the request of the Administration by Chairman G. V. "Sonny" Montgomery and Ranking Minority Member of the Committee, Congressman Bob Stump, is entitled the "Medical Care Cost Recovery Amendments of 1990." This legislation would provide for the recovery by the United States of the cost of medical care and services furnished for a nonservice-connected disability and for other purposes.

More specifically, the measure would permit VA to recover from health insurers the cost of care furnished to a service-connected veteran for treatment of a nonservice-connected disability.

The VFW notes that the VA may now recover from crime victims programs, automobile reparations, insurance, workers compensation laws, and health insurance plans the cost of medical care furnished by the Department for the reasonable cost of care furnished for a nonservice-connected disability. This holds whether or not the veteran also has a service-connected disability. It is only from health care insurers that the VA may not be reimbursed for the cost of providing care for a nonservice-connected disability.

While acknowledging the aforementioned as fact, it must be emphasized that the VFW has in the past, and continues to have philosophical reservations about utilizing nonfederal funds to pay for veterans health care. This of course includes third-party reimbursment to VA for nonservice-connected disabilities. We strongly believe that it is a national responsibility to provide for the health care needs of its military veterans. In our view, any private sector incursion into this area is in a sense a diminishment of federal responsibility, and thereby an erosion of veterans benefits. This was our position when third-party reimbursment for VA health care was provided for in the reconciliation legislation of 1985 and continues to be so.

Nonetheless, we acceded to the establishment of health insurer reimbursment to VA for nonservice-connected injuries because of the desperate need for additional funding by the VA health-care system at the time it was enacted into law. The dire funding problems besetting the VA health-care system have most certainly not lessened since that time, and if anything VA must now provide even more veterans with increasingly expensive care with even fewer constant dollars than in past years. Thus, we continue to accept--albeit reluctantly--third-party reimbursment of VA health care.

This proposal to permit VA to recover the cost of care furnished to a service-connected veteran for treatment of a nonservice-connected disability; however, is something which we may not accept as written. We believe that all category "A" veterans--that is those veterans who are entitled to VA health care by virtue of being both financially and/or medically indigent as well as veterans receiving care for service-connected disabilities--should be excluded from any such proposal.

We do not think that enough thought has been given to what would happen to poor category "A" veterans with nonservice-connected disabilities who have managed to acquire and maintain a modest level of health insurance or who are insured through the policy of a family member. Usually when such economically disadvantaged veterans have some slight health insurance protection, it is either through a personal policy or a small group policy. This means, in our view, that if VA were to recoup the cost of nonservice-connected care from these veterans' insurance providers, their premiums would rise to the point where they would be no longer affordable and, in some cases, policies would be canceled outright. This would not only deprive an already disadvantaged veteran from what minimal additional protection he may have, but also any family members who are also covered under the policy. This would be a travesty and something which the VFW cannot accept.

Even so, while the VFW remains adamant that it is the exclusive responsibility of the Federal government, and by extension VA, to pay for and provide health care for service-connected disabilities, we would not oppose making the law governing nonservice-connected disabilities more consistent with respect to health care insurers, but only for nonmandated care. Category "A" veterans must be excluded.

Thus with respect to category "B" and "C" veterans, the philosophical problems already articulated notwithstanding, the VFW would not object to the reimbursment of VA by health insurers for nonservice-connected disabilities for such veterans with service-connected disabilities.

This legislative proposal would also create a Third-Party Medical Recoveries Fund which would be separate and apart from the medical care account. Amounts collected from third-parties will be deposited in the Fund. The cost of identification, billing and collecting--currently funded from the medical care appropriation--would be defrayed instead out of the collections deposited in the Fund. It is also stated that any excess collections would be deposited in the Treasury as miscellaneous receipts.

In this regard, the VFW is of the opinion that at least a given percentage of any excess revenues should be turned back into the health-care system, on a annual basis, with no offset of fiscal appropriations. This should be done in order to enhance the provision of health care to veterans. We would also point out that it would be desirable to annually retain a sufficient portion of any excess revenues in the fund itself to build a cushion against excessive outlays in future years. In other words, while such a fund should generally generate more receipts than outlays--therefore generating surplus funds--it is also possible in certain years that expenditures will exceed revenues and an appropriation would as a consequence be necessary. By creating the aforementioned cushion, additional appropriations request could be avoided, and other contingencies could be provided for as well.

Another important point, the VFW also notes that the fund would be initially staffed and funded with up to 500 FTEE and $18.6 million transferred from the medical care account resources already devoted to third-party recoveries. It is our view that this Fund should instead be established through a separate appropriation and not through the reduction of the medical care account. The aforementioned 500 employees are not now exclusively dedicated to cost recovery and have other responsibilities within the Department. Thus, VA cannot afford to completely lose the service of these health care employees.

Further, along with the fact that the medical care account simply cannot tolerate any reductions, we would point out that this Fund would also deposit considerable revenues into the United States Treasury. This being the case, it is simply not proper to penalize veterans, even in the short term, by taking Funds from the VA medical care account to start up this Fund. We would also reaffirm our position that it is only fair that VA receive a portion of the revenues generated, on a annual basis, with no offset of appropriations dollars, since it is the insurance that veterans are paying for which would be contributing into the Fund. Further, VA would be provided with additional motivation to pursue recoveries from health care providers since the Department also would directly benefit from the additional revenue, and be better able to provide for veterans' health care needs.

Mr. Chairman, this concludes my statement. Once again, I wish to express to you and the other members of this Subcommittee the thanks of the Veterans of the Foreign Wars for holding today's important hearing and including our views on H.R. 4935. I will be happy to respond to any questions you may have.

STATEMENT OF FRANK C. BUXTON, DEPUTY DIRECTOR
NATIONAL VETERANS AFFAIRS AND REHABILITATION COMMISSION
THE AMERICAN LEGION
BEFORE THE SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
UNITED STATES HOUSE OF REPRESENTATIVES
JUNE 20, 1990

Mr. Chairman and Members of the Subcommittee:

The American Legion appreciates the opportunity to present its views on H.R. 4935 and to present comment on the means test and third party insurance reimbursement programs.

H.R. 4935 - would amend title 38, United States Code, to provide for recovery by the United States of the cost of medical care and services furnished for a nonservice-connected disability, and for other purposes.

Section 2 of this measure would amend subsection 629 (a)(2)(D) of title 38, United States Code, to provide for the recovery of third party reimbursement for care or services provided to any veteran for a nonservice-connected disability, regardless of whether or not he or she has a service-connected disability, if the veteran is entitled to care (or payment of the expense of care) under a health-plan contract.

Mr. Chairman, this proposal would substantially alter the current law under which service-connected veterans are exempt from third party recovery for nonservice-connected disabilities. This proposal is similar to one presented by the Administration in 1989. The American Legion opposed the concept at that time, and remains totally opposed to such a proposal. We adamantly oppose the application of third party recovery to service-connected veterans for any treatment provided by VA.

Section 4 of this measure would amend subsection 629 (g) of title 38, United States Code, to establish in the Treasury of the United States a separate fund to be known as the Department of Veterans Affairs Third Party Medical Recoveries Fund. The Fund will be established with collections from third party medical care cost recoveries and shall be available to the Secretary for reasonable expenses related to the costs of the third party medical recovery program.

Subsection 629 (g) would be further amended to permit the Secretary to transfer to the Fund in Fiscal Year 1991 from the Medical Care Appropriation up to 500 full-time equivalent employees (FTEE) to third party medical recovery activities and sufficient funds to pay the first year salaries of such employees and related costs not to exceed $18.6 million.

Mr. Chairman, the Delegates to The American Legion's 1989 National Convention adopted Resolution No. 160, continuing this organization's opposition to both the means

test and third party reimbursement. However, realizing that these programs are the law of the land at the present time, the National Executive Committee, during its meeting of May 2-3, 1990, adopted Resolution No. 8, which is based on a recommendation set forth by The American Legion's Task Force on Veterans Medical Care in its report of September 1989. As a result of Resolution No. 8, we support the provision of authority for all VA medical centers to retain from third party reimbursement collections all costs of processing such claims. Based on the mandate set forth by this resolution, we support, in general, the provisions contained in section 4.

Section 5 would amend subsection 629 (i)(1)(A) of title 38, United States Code, to establish that a Medicare supplemental insurance policy and medical services covered by such a policy and furnished by VA shall be deemed Medicare-covered services, for the purpose of third party collections.

Mr. Chairman, The American Legion has no specific comment on this proposal, although it must be reiterated that we are mandated to continue our opposition to third party reimbursement.

Mr. Chairman, in addition to presenting The American Legion's views on H.R. 4935, we have been invited to comment on issues raised in two recent General Accounting Office (GAO) reports.

The first report titled, "Medical Centers Need to Improve Collection of Veterans' Copayments", issued in March 1990, assesses whether VA has implemented a cost-effective process for billing and collecting copayments. These collections and associated costs are related to means test billing and collection procedures.

Mr. Chairman, the GAO report examines billing and collection procedures for veterans who were discharged from inpatient care or provided outpatient care between October 1, 1987, and March 31, 1988. GAO reports that during Fiscal Year (FY) 1988, VA collected $9.9 million from veterans at a cost of $7.3 million.

The report further states VA's means test copayment billing and collections program significantly underbilled veterans and should have collected a greater amount of overall billings.

GAO recommends that the Secretary of Veterans Affairs require VA medical centers to collect copayments from veterans or make payment arrangements while veterans are still at the centers.

Mr. Chairman, The American Legion opposed enactment of the means test as legislation that was unnecessary and inappropriate. Delegates to The American Legion's

1989 National Convention adopted Resolution No. 160, which supports legislation to amend Public Law 99-272, so as to retain the entitlement provisions of the Act while eliminating the requirements for the means test.

Experience over the past four years, since its enactment, has established a myriad of problems with the administration of the means test, and it is our view that the GAO recommendation to the Secretary will not rid the program of its inherent weaknesses, but will only serve to compound its failures.

Mr. Chairman, the GAO report is based on FY 1988 data. During that period, the number of Category C veterans receiving care in VA facilities was roughly double what it is today. GAO reports FY 1988 copayment collections of $9.9 million while available information from VA shows FY 1988 copayment collections as totaling $11.8 million. Which figure is correct? GAO reported the FY 1988 cost of administration of the means test program at $7.3 million, based purely on estimated expenditures. It is our understanding VA does not maintain collection costs. Is it possible that GAO also underestimated actual program costs? Available data shows that in FY 1988 there were 80,943 Category C applications for VA care. In FY 1990, during the first six months of the fiscal year, there were 22,490 Category C applications for care. During FY 1990, there will only be half of the number of Category C applicants coming to VA as there were just two years previously. At this rate, costs for administering the means test will outpace collections.

Mr. Chairman, almost four years of experience has proven the means test is not a cost-effective program. Even attempting to implement the GAO recommendation to bill or make arrangements for copayment prior to veterans being discharged from VA facilities or at the time of receiving outpatient care, will only increase staff demands. The costs of administering the means test for the most part, reduces available medical care appropriations.

The following VA data provides a comparison of means test billings and collections since the first full year of implementation, and also includes the estimated FY 1990 totals:

	Billings	Collections
FY 1987	$20.2 million	$ 6.6 million
FY 1988	$14.3 million	$11.8 million

	Billings	Collections
FY 1989	$11.7 million	$ 8.4 million
* FY 1990	$ 8.0 million	$ 6.0 million

* VA estimate

Unfortunately, although the collection process has placed a strain on VA resources, there has not been a groundswell of support in the Congress to rescind the administrative requirements of Public Law 99-272, with regard to the means test. The American Legion believes it is time to repeal the administrative requirements of the means test. In our view, further conduct of this program in its present form will only reduce the amount of funds available for direct patient care, at no appreciable benefit to the United States Treasury.

The second report titled, "Better Procedures Needed to Maximize Collections From Health Insurers", issued in April 1990, addresses the Department of Veterans Affairs collections from health insurers for the cost of care provided to certain insured veterans.

GAO reports in FY 1988, VA spent about $8 million to collect about $100 million from health insurers. Approximately $96 million of these collections were attributable to inpatient health care, the remainder to outpatient care. GAO further estimates that VA collected from insurers only about one-third of the possible collections for medical services provided to insured veterans.

GAO stated in the report that VA could have collected an additional $223 million from insurers in FY 1988, about $180 million for inpatient care and about $43 million for outpatient care. In order to increase billings and collections for medical services provided to insured veterans, GAO submitted several recommendations to the Secretary of Veterans Affairs. These include ensuring that all medical centers bill for outpatient care. In addition, GAO recommends that each medical center have effective procedures for identifying all veterans with insurance and billing insurers for all inpatient and outpatient care provided to insured veterans. It was also recommended that VA be provided sufficient resources to fully implement identification, billing, and collection procedures.

In response to the GAO recommendations, VA has convened a Medical Care Cost Recovery Task Force charged with developing a strategy to improve the aforementioned procedures. In addition, the Veterans Health Services and Research Administration (VHS/RA) now requires all facilities to incorporate billing procedures for outpatient visits. VHS/RA is also establishing procedures for a billing training guide. VA has

planned changes to the Decentralized Hospital Computer Program system that will automate additional portions of the billing process, and establish an accounts receivable module at all facilities.

In order to ensure that sufficient resources are available to fully implement the identification, billing, and collection procedures, VA has presented a legislative proposal which is under consideration today, to transfer 500 full-time employee equivalent (FTEE) positions from the medical care appropriation to the proposed Department of Veterans Affairs Third Party Medical Recoveries Fund in FY 1991. VA has also proposed, according to the budget documents, and additional 300 FTEE for the third party recovery program for FY 1991 to improve third party billings and collections, for a total of 800.

Mr. Chairman, as was indicated earlier in this statement, The American Legion is mandated to support the concept that all VA medical facilities should retain from third party reimbursement collections all costs of processing such claims. However, we steadfastly oppose the application of third party recovery to service-connected veterans for treatment of nonservice-connected conditions.

Over the past several years, VA has not met its third party recovery goals. Now, as fewer Category B and Category C veterans are receiving VA health care, reducing the pool of insured veterans, new sources for meeting VA's cost recovery goals are being sought, as demonstrated in the legislation under consideration today.

The American Legion wonders what is next? Will service-connected veterans be billed for service-connected care? Under the current proposal, service-connected veterans, regardless of their disability rating will be subject to third party billing. It is totally out of line, in the view of The American Legion, to suggest that third party billings be applied to veterans who are statutorily entitled to both VA inpatient and outpatient care.

It is also incongruous to suggest the only VA costs associated with third party insurance are those costs related to the administration of the program. We believe many more personnel will be required to satisfy insurance carrier preadmission certifications. We also believe the wholesale application of the proposal to bill all insurance carriers of severely disabled veterans will represent an invasion of veterans' privacy as VA medical records will have to be verified to ensure that care received is unrelated to the veterans' service-connected disability. On both philosophical and practical grounds, The American Legion opposes the concept of billing service-connected veterans for nonservice-connected health care.

Mr. Chairman, in past debates on the subject of care and treatment provided to veterans, The American Legion has stated that the history of aid and benefits provided to America's veterans which has evolved out of the constant concern of Congress is a record of general devotion to the welfare of those citizens who have given up their normal civilian activities in order to defend the country in times of war and danger to our national safety and security.

Veterans benefits have come to be regarded, therefore, as special, and as benefits to be added to those benefits which the veteran may obtain as a citizen alone. By reason of the peculiar sacrifices and hazards they have many times faced, veterans have become a class of citizens distinguished by unique service to country. The American Legion believes very strongly that if enacted, the proposal to bill service-connected veterans for treatment rendered in VA medical facilities would be another breach of the special covenant historically established between the Congress on behalf of a grateful nation, and the American veteran.

Mr. Chairman, that concludes our remarks.

TESTIMONY OF
FRANK R. DEGEORGE, ASSOCIATE LEGISLATIVE DIRECTOR
PARALYZED VETERANS OF AMERICA
BEFORE THE
HOUSE COMMITTEE ON VETERANS' AFFAIRS
REGARDING
H.R. 4935, THE "MEDICAL CARE COST RECOVERY AMENDMENTS OF 1990"
AND OTHER ISSUES RELATING TO THIRD-PARTY REIMBURSEMENTS FOR THE
DEPARTMENT OF VETERANS AFFAIRS MEDICAL CARE
June 20, 1990

Mr. Chairman, and Members of the Subcommittee, Paralyzed Veterans of America (PVA) appreciates this opportunity to present our views regarding the Department of Veterans Affairs (DVA) medical care cost recovery program. Access to quality health care provided by the Department is an important issue to our members. The proposed legislation being addressed today could greatly effect the care our disabled veterans receive.

H.R. 4935. "Medical Care Cost Recovery Amendments of 1990"

This proposal, introduced by Chairman G.V. "Sonny" Montgomery, and cosponsored by the Ranking Minority Member, the Honorable Bob Stump, (at the request of the Administration) recommends several strategies aimed at increasing the collection of receipts from third-party payers for the cost of providing health care to certain eligible veterans who carry private health insurance.

Aside from enhancing the Department's current ability to collect from third-party payers, this legislation also extends similar authority for DVA to collect from third parties reimbursement for the cost of treatment provided to service-connected veterans for their nonservice-connected disabilities.

In order to pursue the collection of such receipts, the Department is requesting the transfer of no more than 500 full time equivalent employees (FTEE) and no more than $18,600,000 from the medical care account. These funds and employees are to be transferred to a separate fund to be known as the "DVA Third-party Medical Recoveries Fund." This fund is to be established within the U.S. Treasury for the purposes of maintaining the receipts collected by DVA. Furthermore, the Administration proposes that from this fund the Department recoup the expenses of collecting third-party receipts, the remaining balance being obligated to the Treasury for miscellaneous purposes.

Section 2

Section two of this legislation would provide DVA with the legislative authority to collect from third-party payers not only the cost of care and services to nonservice-connected veterans, but also for the medical treatment provided to service-connected veterans for their nonservice-connected disabilities.

In this time of fiscal restraint and growing budget deficits, we can understand the need for DVA to seek alternative methods of revenue enhancement. However, this proposal to collect receipts from third-party payers for the cost of medical care to service-connected veterans for nonservice-connected disabilities is clearly not in the best interest of the Department, the veteran population, or the public. We see this proposal as another in a long list of options designed to increase fees, co-payments and reimbursements requiring the veteran to continue to pay more and more for services which historically have been provided by the federal government.

According to the December 1989 Survey of Disabled Veterans, half of all service-connected disabled veterans exhibit at least one or more nonservice-connected disabilities which require medical treatment.

Currently, these disabled veterans, rated 50 percent or more, are entitled to DVA medical treatment for their nonservice-connected disabilities. Although 75 percent of these disabled veterans presently maintain private health insurance coverage, as they age, this coverage becomes more difficult to continue. Therefore, as the veteran population rapidly ages, the number of veterans holding private health insurance policies from which DVA may collect reimbursements will significantly shrink.

By expanding collections from third parties for the cost of medical care, DVA is establishing a dangerous precedent which could increase health care insurance premiums to the population as a whole. In this case, the expense of care is shifted to the private health insurance sector. These insurers, in turn, must shift the cost burden to the Nation's health care policy holders whether they be disabled veterans or not.

The Department states that this proposal is necessary in order to make their Third-party Medical Care Cost Recovery Program more consistent. Mr. Chairman, attempting to make this cost recovery program more consistent between service-connected and nonservice-connected veterans is no reason at all to change existing law. Title 38, USC, mandates that service-connected disabled veterans, rated 50 percent or more, are entitled to medical care and services provided by the Department regardless of insurance status. This law clearly demonstrates that veterans with service-connected disabilities have the highest degree of priority within the DVA system. Requiring collection of third-party receipts for the cost of medical treatment currently provided under existing law, would undermine historic legislative intent established in Title 38, USC, and be a serious breach of commitment to our Nation's veterans.

Section 4. Department of Veterans Affairs Third-party Medical Recoveries Fund

Although all collected insurance money is currently deposited into the General Fund of the U.S. Treasury, no mechanism exists to reimburse DVA for the cost of collection. The Administration's proposed legislation, however, aims to correct this by allowing DVA to recoup the costs of an expanded Medical Care Cost Recovery Program through a fund established in the Treasury Department.

While PVA would support an enhanced budget to aid in third-party collection, we encourage the establishment of a procedure in which funds collected will be deposited into the DVA Medical Care Account to improve health care for eligible veterans--as opposed to these funds being deposited into the General Account of the U.S. Treasury. At the present time, however, DVA could withhold some of these collected funds, but would undergo the risk of having future budgets offset accordingly by the Office of Management and Budget (OMB), making this proposal unworkable at this time.

Despite assurances to the contrary, we do not believe a concrete formula has been derived to secure the receipt of these third-party payments by DVA in order to enhance medical care programs. If the current Secretary and the current Director of OMB have reached such an agreement, and if this agreement is sound and firm, then PVA urges the same agreement be expanded to allow DVA to keep all third-party receipts. We remain concerned, however, that present agreements between the current Secretary and current OMB Director might fail the test of time for future Secretaries, future OMB Directors and future Administrations.

Mr. Chairman, we commend the efforts of this Committee for their diligent efforts toward finding a solution to this dilemma. Although no concrete assurance has been provided by OMB to deter budgetary repercussions should DVA utilize these third-party payments, we are hopeful that the Committee can develop such a guarantee through legislation in the near future.

Section 4. Transfer of Employees and Funds From Medical Care Appropriation

In another effort to enhance the current Medical Care Cost Recovery Program, the Administration is seeking authorization to utilize DVA staff (500 FTEE) and medical care funds ($18,600,000) during Fiscal Year 1991 to enhance collection efforts. Mr. Chairman, PVA expresses great concern over this particular provision. DVA is in the middle of a funding crisis, a crisis in which medical centers are curtailing programs and services due to a lack of funding. We note that although this collection program is a priority of the Administration, proposed Fiscal Year 1991 appropriations do not provide specific authorization for an additional $18 million for this purpose. Regardless of the amount of funds anticipated to be recovered, this transfer

of FTEE and funds in Fiscal Year 1991 will create a serious drain on an already over-burdened system. In other words, placing DVA in the role of "bill collector" will potentially decrease resources available to provide medical care to our Nation's veterans now and in the future.

GENERAL ACCOUNTING OFFICE REPORT
VA HEALTH CARE: Better Procedures Needed to Maximize Collections from Health Insurers
April 1990

In its recent report, "Better Procedures Needed to Maximize Collections from Health Insurers," the General Accounting Office (GAO) evaluated the Department's current system of collecting reimbursements from health insurers for the cost of care provided to certain insured veterans.

As you know, Congress in 1986 authorized DVA to pursue the collection of third-party payers for the cost of health care provided to certain nonservice-connected veterans. However, GAO reports that only one-third of possible collections were recovered in Fiscal Year 1988 by the Department due to inadequate resources and collection techniques. Furthermore, GAO recognized that many medical center directors were unable to initiate such collection efforts due to medical care funding restraints. Among their recommendations to achieve greater recoveries, GAO suggested revised management techniques, enhanced equipment, and the legislative authority for DVA to recoup the costs of collection activities from funds collected.

In response to GAO's report and recommendations, DVA reviewed the cost of establishing such a comprehensive collection system as proposed by GAO. DVA estimates that $18.6 million and 500 FTEE would be required from the medical care account along with an appropriation of an additional $6.4 million and 300 FTEE to thoroughly collect third-party receipts.

As a point of reference, DVA spent approximately $8 million in Fiscal Year 1988 to collect $100 million in third-party payments. Therefore, if the above described resources were implemented, GAO estimates that DVA could have collected an addition $233 million in that same fiscal year, all of which would have been returned to the Treasury.

Mr. Chairman, we support DVA's efforts to follow current law. Since DVA is mandated to pursue the collection of third-party payments for the cost of medical treatment provided to certain nonservice-connected veterans, the Department should be provided adequate resources to carry out this stipulation. However, we have previously stated our concern over the return to the Department of any receipts from third-party collections. Despite "agreements" and "understandings" with OMB to the contrary, we remain concerned that OMB will use those collection offsets to decrease funding for needed program costs in future budgets.

GENERAL ACCOUNTING OFFICE REPORT
VA HEALTH CARE: Medical Centers Need to Improve Collection of Veterans' Copayments
March 1990

Public Law 99-272 provides the authority for DVA to collect from "Category C" eligible veterans for medical care and services received in a DVA facility. According to the March 1990 GAO report, "Medical Centers Need to Improve Collection of Veterans' Co-Payments," 159 medical centers collected approximately $9.9 million in co-payments from certain veterans at a cost of $7.3 million during Fiscal Year 1988. The rate of co-payments charged to "Category C" veterans in 1988 were $25 per outpatient visit and $540 for the first 90 days of inpatient care.

GAO's findings indicate that co-payments from veterans were not consistently collected in Fiscal Year 1988 resulting in a loss of $386,000 during the first six months of that year. Based on their findings, GAO recommended to the Secretary of DVA that medical centers improve their billing and collection practices to increase co-payment collections at reduced costs.

PVA supports enhanced efforts to collect co-payments from "Category C" veterans. However, DVA should be cautioned to avoid aggressive collection efforts which could serve to inhibit veterans from seeking health care. GAO indicates that out of 159 medical centers, veterans at 71 centers (who neglected to pay their co-payments) frequently stated that they could not afford to pay the amount due. Should the Department pursue aggressive collection techniques from these veterans, DVA may possibly eradicate the

last opportunity for these veterans to obtain health care. DVA must remember its sole mission is to serve the Nation's veterans.

It must also be mentioned that fewer and fewer "Category C" veterans are able to obtain health care in DVA medical facilities due to budget cutbacks. If this trend continues, potential receipts from these veterans--in the form of co-payments--will be minimal. Therefore, in the long run, it appears likely that to enhance effort and expense to collect these co-payments will provide little return for the general Treasury or DVA itself.

Mr. Chairman, this concludes my statement. I will be happy to answer any questions.

STATEMENT OF
DAVID W. GORMAN
ASSISTANT NATIONAL LEGISLATIVE DIRECTOR
FOR MEDICAL AFFAIRS
DISABLED AMERICAN VETERANS
BEFORE THE
SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
COMMITTEE ON VETERANS AFFAIRS
U.S. HOUSE OF REPRESENTATIVES
JUNE 20, 1990

MR. CHAIRMAN AND MEMBERS OF THE SUBCOMMITTEE:

On behalf of the 1.3 million members of the Disabled American Veterans and its Ladies' Auxiliary, I want to say how very much we appreciate the opportunity to appear today to discuss the Department of Veterans Affairs' (VA) Medical Care Cost Recovery Program -- third party reimbursement.

H.R. 4935

Introduced by yourself, Mr. Chairman, at the request of the VA, Section 2 of H.R. 4935 proposes to amend Section 629(a)(2)(D), Title 38, USC extending the VA's authority to recover -- third party reimbursement -- the cost of care provided to a service-connected disabled veteran when treated for a nonservice-connected disability.

Mr. Chairman, the DAV is adamantly opposed to this measure.

In our view, H.R. 4935 contains the obvious theme of radically restructuring the veterans' health care system in an overly restrictive manner and sends a clear signal to service-connected disabled veterans that yet another earned benefit and entitlement is being stripped from them.

A secondary theme exists: to simply discourage and force a large number of veterans away from the VA thus diminishing the base and patient mix of veterans accessing and utilizing the system. The end result is simply a foothold at dismantling the system to a point of ineffectiveness.

In this regard, we view this proposal as an attempt to require veterans to pay for the privilege -- extended by Congress and a grateful nation -- of utilizing earned VA benefits and, in fact, entitlements under current law.

Additional concerns become readily apparent which deserve some discussion and further buttresses our view that this measure is not in the best interest of disabled veterans, nor for that matter the VA.

We believe the adjudicative/administrative nightmare that would be imposed on the VA would be exceedingly burdensome and create havoc in a system already taxed to the breaking point.

As an illustration, consider the case of a World War II veteran, service-connected for an amputation of the lower extremity, upper third, resulting from combat incurred gunshot wounds who is admitted to a VA medical center and treated for chronic lumbosacral strain with degenerative disc disease.

At the time of admittance and, in all likelihood at the time of discharge, from the hospital and for sometime thereafter, the veteran's chronic back condition may not be an adjudicated service-connected disability.

Under the provisions of H.R. 4935, the VA would, presuming the veteran had health care insurance, initiate action to

collect the reasonable cost of care and services provided from the insurance carrier and, in fact, receive reimbursement.

However, at some point in the process, a claim will have been filed and adjudicative action taken by the Veterans Benefits Administration to grant service-connection for the chronic back condition as a logical consequence and proximate result of the service-connected amputation.

It is not unreasonable to consider a claim of this nature would require, under the most favorable scenario, a minimum of three months to a maximum of 467 days to adjudicate under normal conditions utilizing the appellate process.

How then, Mr. Chairman, is the entire process rectified concerning the responsible third party payer?

Let's examine the ramifications of H.R. 4935 under the budget process regarding VA health care.

Under current law, whatever monies VA is successful in collecting is deposited in the United States Treasury.

It is currently estimated that in Fiscal Year 1990, $135 million, out of an original goal of $275 million, will be collected by the VA from third party payers. Actual collections in Fiscal Years 1988 and 1989 were $100 million and $130 million, respectively.

If, in the formulation of future VA budgets the amounts collected and retained by VA are calculated and considered in the overall health care account, then the current budgetary shortfall would be greatly exacerbated as the collectable estimates are grossly overstated and the actual amount collected considerably less than estimated.

Mr. Chairman, the provisions of H.R. 4935, if enacted into law, would be bad for veterans and bad for the VA. We reiterate our adamant opposition to this measure and urge the Subcommittee to reject this proposal.

Section 3, as we understand it, proposes to clarify the degree of liability of veteran insurers for the cost of medical care provided.

If private insurance providers are arbitrarily "discounting' charges for VA medical services (as appears may be occurring) then, it seems VA is not being treated fairly or in a similar manner with other health care providers.

Mr. Chairman, it appears that this provision would address that concern by extending the insurance carrier the option of reimbursing VA at the rate established by the Secretary or at the usual and customary rates paid for like services in the community.

Mr. Chairman, Section 4, would create the, "Department of Veterans Affairs' Third Party Medical Recovery Fund", for the purpose of, as we understand it, funding the Department's third party recovery efforts.

Currently, VA's recovery efforts are funded, in their entirety, from the medical care appropriation. All administrative functions, such as identification of veterans with insurance coverage, billing their providers, and collections are conducted at the expense of providing direct health care services to disabled veterans.

The current practice of robbing scarce medical care dollars to fund an effort that has absolutely no direct benefit to either the VA or disabled veterans makes absolutely no sense. Establishment of such a fund and the perceived intent of the fund may remedy this otherwise illogical situation.

Mr. Chairman, Section 5 appears to have the intent of clarifying VA's authority to collect from the so-called "medigap" policies for the care provided to certain veterans.

As indicated previously, Mr. Chairman, the DAV is, and will remain adamantly opposed to any effort to grant authority to recover, from third party insurance carriers, the cost associated with providing VA medical care services to service-connected disabled veterans.

Since April 1986, with the enactment of Public Law 99-272, the VA has had the authority to collect third party reimbursements for medical services provided to certain well defined disabled veterans.

Clearly, the implementation of a workable mechanism to effectively do so has been both slow and ineffectual. VA has recognized their own limitations in this regard. Also, the General Accounting Office (GAO) has recently released two separate reports; (1) VA Health Care: Better Procedures Needed To Maximize Collections from Health Insurers (GAO/HRD-90-64); and (2) VA Health Care: Medical Centers Need to Improve Collection of Veterans' Copayments (GAO/HRD-90-77). Both of these reports have clearly identified the difficulties and shortcomings experienced by VA in this regard.

Mr. Chairman, in our view, it makes good sense for the VA to be moving in the direction of maximizing, to the fullest extent possible, their efforts to collect whatever is due them from private health care providers. However, not at the expense of disabled veterans.

Mr. Chairman, the DAV is supportive of efforts to collect what is owed VA under existing law. We do, however, wish to note our concern and opposition to the enactment of any statute or procedure that would enhance the VA's recovery efforts at the continuing expense of the medical care account. We would continue to be opposed to any "shell games" that would utilize an unrealistically high collectable amount, from third party insurers and, predicated on that, have a direct, or indirect bearing on future appropriations of health care dollars.

Mr. Chairman, with the above concerns noted, we would not necessarily oppose the enactment of Sections 3, 4 and 5 of H.R. 4935.

Mr. Chairman, this concludes my testimony and I would be pleased to respond to any questions you may have.

WRITTEN COMMITTEE QUESTIONS AND THEIR RESPONSE

QUESTIONS OF HON. G.V. (SONNY) MONTGOMERY

1. What is your opinion about the Birch and Davis suggestion that contractors be reimbursed on an "at-risk" basis from collections rather than a set fee? Would this, in fact, tend to reduce costs?

   GAO response: Reimbursing contractors on an "at risk" basis for their insurance recovery activities could be an effective means of maximizing the total amounts collected. More importantly, it would allow VA to lock-in a guaranteed rate of return. For example, if a contractor's payment was set at 10 percent of the amount collected, then VA would realize a return of $9 for each $1 spent. Setting the contractor's reimbursement rate is the key element in minimizing VA's costs; in theory, it should be set at a rate that would result in lower costs than VA could achieve doing the collections in-house.

2. The VFW raised in testimony the idea that health insurance premiums would rise if nonservice-connected care were to be collected from service-connected veterans. GAO performed some studies of health insurance costs some years ago. What is your view of the VFW idea?

   GAO response: A 1985 GAO report (GAO/HRD-85-24, Feb. 26, 1985) estimated, based on the benefits paid and administrative costs at that time, that insurance premiums would increase between $0.93 and $2.69 per year for each policyholder with comprehensive hospitalization coverage if the companies passed on the benefit payments and administrative costs to all of their policyholders. In actual practice, the extent that insurers would increase premiums would depend on a number of factors including the competitive environment and the change in total claims received. GAO has not performed any recent analysis to determine whether, or the extent to which, insurance companies would increase their premiums.

3. The Department of Veterans Affairs estimates that $400 million can be collected above current experience from third parties and copayments. Do you agree?

   GAO response: VA's estimate appears reasonable but it may take one or two years before VA reaches its full potential, given the significant number of improvements that must be made to its recovery processes. In an April 1990 report, GAO estimated that VA could have collected an additional $223 million from insurers of nonservice-connected veterans in fiscal year 1988, based on 1988 workload and rates. Moreover, the estimates showed that the additional revenues may have been as high as $373 million in that year. In addition, VA estimates it could collect an additional $111 million per year if it was authorized to collect from insurers of service-connected veterans being treated for nonservice-connected conditions.

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4. Birch and Davis testified that the VA's current automated accounts receivable systems are not adequate for billing. Do you agree?

   GAO response: The recent GAO report (GAO/HRD-90-64, Apr. 6, 1990) concluded that VA's billing systems were inadequate. The report also pointed out that VA was developing an automated billing system that will allow billing clerks to use data already in the computer to prepare a bill, track bills and generate follow-up letters for overdue bills. The report questioned, however, whether the automated system will significantly reduce the staff time needed to prepare outpatient bills because the billing staff will continue its labor-intensive procedures to verify and document the care provided.

5. You suggested that the VA use either contracting or in-house staff to improve collections. How might the Department judge which is the most effective, especially in view of the large investment in in-house resources proposed by the VA?

   GAO response: VA, and its individual medical centers, must first design the most efficient processes for identifying, billing, and collecting from insurers and then determine its implementation costs for each phase. Tasks which can be performed by private sector companies should be identified and costs determined. VA medical centers should consider contracting for all areas where a cost savings could be achieved.

6. The Department is requesting about 800 personnel and $25 million to collect from third parties. Do you agree that this is an appropriate quantity of support?

   GAO response: GAO believes that the Department's request represents an appropriate level of support for fiscal year 1991. It will provide an average of five staff for each medical center. GAO's work showed that VA spent $8 million to collect $100 million in fiscal year 1988 and many of VA's improvements should result in a more efficient collection system. Also, as additional experience is gained, VA will be able to more accurately estimate the number of staff actually needed to identify, bill, and collect from insurers and the authorized levels for the fund could be adjusted accordingly.

7. GAO criticized VA's manual procedures in third party and copayment collections. Do you believe that the VA has the computer capability to generate bills to improve third party collections?

   GAO response: GAO's visits to medical centers found that they were not maximizing the use of computer capability to improve the efficiency of the collection process. However, since then, VA has established, as a priority, a plan to review and evaluate its computer software to enable more efficient identification, billing, and collection procedures.

QUESTIONS SUBMITTED BY HON. JOHN PAUL HAMMERSCHMIDT

1. Do you believe that the VA's top management is demonstrating a more active role in helping medical centers maximize collections from health insurers? After reviewing H.R. 4935 is there any issue you believe the VA has overlooked?

   GAO response: VA's top management has demonstrated a more active role in helping medical centers maximize collections by (1) listing the recovery processes as material weaknesses in VA's Federal Managers' Financial Integrity Act report for fiscal year 1989, (2) establishing a top-level management team to develop a comprehensive plan for improving VA's recovery procedures, and (3) developing a legislative proposal to finance the insurance recovery efforts. In this regard, GAO has not identified any additional issues that should be addressed in H.R. 4935.

THE SECRETARY OF VETERANS AFFAIRS
WASHINGTON

AUG 30 1990

The Honorable G. V. (Sonny) Montgomery
Chairman, Committee on Veterans' Affairs
House of Representatives
Washington, D.C. 20515

Dear Mr. Chairman:

Enclosed please find the responses to questions submitted by you and Representative John Paul Hammerschmidt following the Subcommittee on Hospitals and Health Care's June 20, 1990, hearing on provisions in H.R. 901 and H.R. 4935, pertaining to third-party reimbursement. A copy of the responses has been provided to Representative Hammerschmidt.

Sincerely yours,

Edward J. Derwinski

Enclosures
EJD/flc

CONGRESSMAN MONTGOMERY

Question: 1. In its FY 1991 budget, the Department of Veterans Affairs (DVA) requested a $26 million decrease in funding for DBCP. How would this affect the DVA's ability to bill and collect third party payments?

Answer: The FY 1991 budget request was sufficient to maintain DBCP at its current level (CORE plus 8). That request did not provide resources for automating the billing and third party collection functions.

Question: 2. Did the DVA consult with veterans service organizations with regard to your proposal to collect for non-service connected care from service-connected veterans?

Answer: Yes, VA did consult the National Veterans Service Organizations (VSO's) concerning our proposal to bill service-connected veterans for treating non-service connected conditions. Mr. McCann, the Chief Financial Officer of the VA, met with the National VSOs and discussed our proposed legislation for FY 1991.

Question: 3. Currently, medical center directors are reluctant to use scarce personnel and monies for third party collections. Why then should the medical care account absorb the majority of the upfront cost of the Department's third party reimbursement program?

Answer: It was our estimation that there are currently approximately 500 FTE performing third party collection activities already so those FTE should appropriately be moved to the new appropriation. After the fund is approved and we have experience with it we can make further requests for resources to collect third party collections.

Question: 4. Birch and Davis testified that the DVA's current automated accounts receivable systems are not adequate for billing. Do you agree?

Answer: We are currently producing the majority of our third party billings from our own billing system. We are continually working to improve our billing system and in the near future our plans are to have a completely automated inpatient bill.

Question: 5. In it's report on DVA's third party collection, GAO stated that the DVA did not identify a substantial portion of veterans who had insurance and who could have been billed. What specific steps are in your proposal to address this problem?

Answer: A great deal of emphasis has been placed on this issue. GAO was correct in identifying this as a major weakness in our present system. We are stressing interviewing techniques and obtaining access to insurance data bases in order to check for veterans with insurance. The key is obtaining the information from the veteran or his/her spouse at the same time we are gathering other pertinent data. This will be stressed locally and at our national training conference.

Question: 6. The DVA has had a long history of successfully contracting out services that were already performed in-house. Why is the Department now pushing to do third party billing and collecting in-house where no significant capacity exists?

Answer: VA is advocating a flexible approach to the third party functions of identification, billing, follow-up and collections. This is what our field facility program managers tell us they need. Contracting has its place as do in-house efforts. The purpose is to recover the maximum of the reasonable costs of care through the most effective means as efficiently as possible. Over the last four years, we have developed a base of experience, procedures, systems and resources that represents a significant capacity.

Approximately 500 FTEE are now assigned to third party recovery efforts. Our plan is to mobilize those resources together with the 300 additional FTEE requested in the FY 1991 Budget to create an effective program. The national "menu" contract will allow medical centers to purchase services as needed. However, as many of our medical centers have already demonstrated, the most cost effective approach for many of these services is in-house. Further some of these services such as interviewing veterans at intake or on the wards is an inherently VA function. Other functions such as collecting bills from insurers who do not respond, electronic billing and insurance identification systems may be more inherently commercial in nature.

Question: 7. Billing for outpatient care is very labor intensive. What specific steps are proposed to improve third party collections for outpatient care?

Answer: Billing procedures for outpatient care is very labor intensive. One of the reasons that outpatient billing is not easily automated is because VA has never required the coding of the diagnosis and treatments provided on an outpatient basis. Both items are required to be coded for the insurance industry to accept outpatient bills for payment. Discussions have been held with VHS&RA staffs on mechanisms that could be adapted or enhanced to facilitate outpatient billing.

Question: 8. GAO testified that medical centers sometimes have to wait "several weeks to several months" for doctors to prepare medical discharge summaries. Testimony before this Committee suggests that inadequate staff in clerical positions is a serious problem. How will your plan to improve collections address this problem?

Answer: Additional clerical support is not required for physicians to dictate the hospital discharge summaries. VA manuals require that hospital summaries are dictated prior to patient discharge. Our plan will emphasize compliance with these requirements.

Question: 9. What is your opinion of the capability of the DVA to generate bills for care that will be accepted by the private insurers?

Answer: We are presently able to generate bills for care that are acceptable to third party insurers. We are effectively dealing with the different requirements insurance companies have from state to state. We are improving our automated billing systems in order to produce bills in a more expeditious manner and to comply with changing insurance company requirements.

Question: 10. GAO recommended that collections of copayments be made before the veterans leave the hospital. Do you believe that this is a practical suggestion, since private hospitals do this?

Answer: We currently do not have the capability to produce a bill for the copayment at the time of the veteran's visit to the medical center. This is a feasible suggestion and we are developing plans including identification of necessary equipment to accomplish this.

Question: 11. There has been an almost complete elimination of care for Category B and C veterans. How does this affect your projections for increased collections?

Answer: Our projections are based entirely on Category A non-service connected veterans who use the VA medical system. Category B and C veterans are not factored in at all because of the change you identified (less than 5 percent currently treated are B or C).

Question: 12. Do you think it is possible and desirable to collect copayments using the same system that you propose to use for third party collections?

Answer: We are using the same system for both billing and collections presently. It has not presented major problems to date.

Question: 13. Birch and Davis suggest that contractors might aid the DVA in one or more of the following collection tasks: admissions, processing of bills and collection of payments. Do you agree?

Answer: We would agree that there is a role for contractors to aid some medical centers in processing bills and in collection of payments. This would be particularly true for bills VA is unable to collect from insurers. Regarding admissions, this is, for the most part, an inherently VA function in that all veterans must be interviewed at intake where insurance information is only one portion of that interview. Again, a flexible approach seems to be the most appropriate course.

Question: 14. The DVA proposes to drain the medical care account of almost $20 million to aid in improving collections of third party reimbursements. The medical care account is widely acknowledged to be short. Why did you not request additional funding?

Answer: There is $18.6 million already in the base for third party recoveries representing costs associated primarily with the approximately 500 FTEE now implementing the program. These resources are simply being transferred to the fund account and represent no diminution of direct medical care resources.

CONGRESSMAN HAMMERSCHMIDT

Question: 1. Do you plan to seek third party reimbursement for medical conditions which are derived from service-connected disabilities? (For example, a veteran who suffers an injury which impairs mobility and subsequently develops a back condition). Is it true that in certain circumstances it is difficult to determine whether or not a medical condition is a secondary result of a service-connected condition? Who would decide in those cases?

Answer: Legislation has been proposed to collect for the cost of medical care provided to service connected veterans for the treatment of their non-service-connected conditions. The medical staffs (i.e., treating physicians) would be required to make a determination as to whether the treatment provided for the condition was related to the service connected disability.

Question: 2. Do you believe it is worthwhile for the VA to apply program enhancements to collections of copayments or would it be better to apply scarce resources to recovering from health insurers?

Answer: By providing enhancements to the collection of copayments the maximum possible total recovery would be approximately $25.0 million. If we provided those same enhancements to third party collections there is a possibility of far greater amounts to be collected and returned to the Treasury. Therefore, we are placing emphasis on third party collections.

Question: 3. In 1988, the VA collected $9.9 million in copayments at a cost of $7.3 million. At the same time, the VA collected $100.0 million from health insurers at a cost of only $8.0 million. Why does it cost the department a higher proportional amount to collect copayments than it costs to collect from health insurer's?

Answer: It costs roughly the same amount of money to prepare a bill for either program. In the majority of medical centers, the same staffs associated with copayment billings also perform third party billing functions. The disparity between the two billing processes can be attributed to the dollar value of the respective bill, for example, the copayment is $23.00 as compared to several thousand for third party billing.

Question: 4. What is the VA's estimate of how much could be collected from so-called MEDIGAP policies?

Answer: The estimated potential recoveries from Medigap policies for FY 1991 is $215.8 million, rising to $221.0 million by FY 1995. Of that potential, VA estimates that we could reach approximately 50 percent of that potential in FY 1991 or approximately $108.0 million.

Question: 5. Please describe the VA's plans and estimated timeline for automation improvements necessary for efficient operation of the Department's Medical Cost Recovery Program?

Answer: We plan to release new software in September 1990 that will enhance our inpatient billing capabilities and in FY 1991 plan to almost totally automate the inpatient bill. Our automated outpatient billing capabilities are not well developed. We are seeking to procure additional DHCP hardware (FY 1992 bar code readers and printers) that will assist us in the automation of outpatient bills.

John L. McClellan Memorial Veterans' Hospital
4300 West 7th Street
Little Rock AR 72205

Veterans Administration

July 25, 1990

In Reply Refer To: 598/04

Honorable G. V. (Sonny) Montgomery
House of Representatives
Washington, D. C. 20515

Dear Mr. Montgomery:

As requested in your letter of July 3, 1990, I have enclosed the completed questionnaires regarding third party billing.

If I can be of further assistance, please do not hesitate to call.

Sincerely yours,

Harry L. Guillote

HARRY L. GUILLOTE
Chief, Fiscal Service

Enclosures

QUESTIONS SUBMITTED BY HONORABLE JOHN PAUL HAMMERSCHMIDT
TO DEPARTMENT OF VETERANS AFFAIRS MEDICAL CENTER
LITTLE ROCK, ARKANSAS
AT THE SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
JUNE 20, 1990
THIRD PARTY REIMBURSEMENT

1. HAVE YOU COMPARED THE COST-EFFECTIVENESS OF CONTRACTING OUT THIS FUNCTION AS OPPOSED TO KEEPING IT IN-HOUSE?

While the possibility of contracting out this function has been discussed among Fiscal Officers, there is not enough data accumulated to support a "for" or "against" recommendation.

2. ARE THERE ANY INCENTIVES OR UNIQUE CIRCUMSTANCES CURRENTLY IN PLACE AT YOUR MEDICAL CENTERS THAT MIGHT EXPLAIN WHY YOU ARE EXCELLING IN THIS AREA AT A FAR GREATER RATE THAN OTHER MEDICAL CENTERS?

Collections have been designated a priority area. Additionally, there is a high level of cooperation among Fiscal, Medical Administration, and Utilization Review groups characterized by sharing of information through frequent meetings and telephone calls.

3. DO YOU HAVE AN ESTIMATE ON HOW MUCH OF AN INCREASE IN COLLECTIONS YOUR FACILITY WOULD ACHIEVE IF YOU COULD SEEK REIMBURSEMENT FOR TREATMENT OF NON-SERVICE CONNECTED CONDITIONS OF SERVICE-CONNECTED VETERANS?

A four-member project team conducted a review of 1988 demographic data that included cases of SC veterans being treated for NSC conditions. This facility would estimate a 20% increase in collections.

4. DOES YOUR FACILITY EXPERIENCE DIFFICULTIES IN COLLECTING CO-PAYMENTS FROM VETERANS? IF SO, WHAT ARE THE DIFFICULTIES?

Any difficulties in collecting co-payments from veterans normally stem from the veterans not expecting to be billed. Most often the veteran will pay once the law is explained to him.

QUESTIONS SUBMITTED BY HONORABLE G. V. MONTGOMERY
TO DEPARTMENT OF VETERANS AFFAIRS MEDICAL CENTER
LITTLE ROCK, ARKANSAS
AT THE SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
JUNE 20, 1990
THIRD PARTY REIMBURSEMENT

1. HAVE YOU BEEN ABLE TO COMMIT THE NECESSARY RESOURCES AND PERSONNEL FOR THIRD PARTY BILLING AND COLLECTION? IF NOT, WHY?

Budgetary constraints prevent full allocation of personnel and resources for billing and collection. Minimal staffing to effectively operate follow-up and collection activities for third parties have been allocated to date.

2. WITH THE FOCUS ON INCREASING COLLECTIONS, MORE EFFORT WILL BE PLACED ON IDENTIFYING THOSE VETERANS WITH INSURANCE. MIGHT THIS RESULT IN TURNAWAYS OF SOME VETERANS NOT MANDATED CARE WHO DO NOT HAVE PRIVATE INSURANCE?

We don't anticipate these efforts as having an adverse effect on any veterans presently being treated. With the patient population remaining constant, our goal is to do a better job of identifying those now being treated who have insurance.

3. WHAT HAS BEEN YOUR EXPERIENCE IN COLLECTING CO-PAYMENTS? WHAT ARE THE PROBLEMS?

Any difficulties in collecting co-payments from veterans normally stem from the veterans not expecting to be billed. Most often, the veteran will pay, or make an effort to pay, once the law is explained to him.

John L. McClellan Memorial Veterans' Hospital
4300 West 7th Street
Little Rock AR 72205

Veterans Administration

JUL 2 4 1990

In Reply Refer To: 598/136LR

Honorable G. V. (Sonny) Montgomery
House of Representatives
Washington, D. C. 20515

Dear Mr. Montgomery:

As requested in your letter of July 3, 1990, I have enclosed the completed questionnaires regarding third party billing.

If we can be of further assistance, please do not hesitate to call upon us.

Sincerely,

JOHN K. HAYCRAFT, Chief
Medical Administration Service

Enclosures

QUESTIONS SUBMITTED BY HONORABLE JOHN PAUL HAMMERSCHMIDT
TO DEPARTMENT OF VETERANS AFFAIRS MEDICAL CENTER
LITTLE ROCK, ARKANSAS
AT THE SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
JUNE 20, 1990
THIRD PARTY REIMBURSEMENT

1. HAVE YOU COMPARED THE COST-EFFECTIVENESS OF CONTRACTING OUT THIS FUNCTION AS OPPOSED TO KEEPING IT IN-HOUSE?

No cost comparison has been done.

2. ARE THERE ANY INCENTIVES OR UNIQUE CIRCUMSTANCES CURRENTLY IN PLACE AT YOUR MEDICAL CENTERS THAT MIGHT EXPLAIN WHY YOU ARE EXCELLING IN THIS AREA AT A FAR GREATER RATE THAN OTHER MEDICAL CENTERS?

We feel our system is unique in that we have several different services in separate locations working closely to administer a collections program that is doing an excellent job. This teamwork is possible because much thought and planning has gone into selection of personable, outgoing, aggressive personnel and flexibility in job responsibilities, as well as total support by managers at our medical center. We rely almost totally on our computer system making the most of programs designed for MCCR. Incentives are mainly through praise and recognition rather than financial, although during the past year, several monetary incentives have been established. Both methods are important. An effort has been made to publicize the huge effort made by the medical center's MCCR personnel. Newsletter articles, discussion in staff meetings, awards ceremonies, etc. have been used to inform and educate all medical center personnel of the good job that has been done.

3. DO YOU HAVE AN ESTIMATE ON HOW MUCH OF AN INCREASE IN COLLECTIONS YOUR FACILITY WOULD ACHIEVE IF YOU COULD SEEK REIMBURSEMENT FOR TREATMENT OF NONSERVICE-CONNECTED CONDITIONS OF SERVICE-CONNECTED VETERANS?

Based on the number of nonservice-connected veterans who have insurance, it is estimated that 13-14% of service-connected veterans will have insurance.

In FY-89 applications from service-connected veterans were broken down as follows:

More than 50%	10-40%	Less than 10%
4,361	5,754	1,973

The average bill for FY 89 was $3,447.

TOTAL 12,088 X 13% = 1,571 X $3,477 = $5,462,367

If only the less than 10% group was billed (This group would have the service-connected conditions most clearly identifiable without medical review. For instance most of this group would have only one service-connected condition, i.e., flat feet, sinusitis, tinnitus, etc.). This would have resulted in an additional $882,432 in FY89.

1,973 X 13% = 256.49 256 X $3,447 = $882,432

4. DOES YOUR FACILITY EXPERIENCE DIFFICULTIES IN COLLECTING CO-PAYMENTS FROM VETERANS? IF SO, WHAT ARE THE DIFFICULTIES?

In the beginning, some problems were encountered. These were usually because of lack of knowledge. A concerted effort has been made to explain the co-payment process to the veterans in speeches to Veterans Service Organizations, handouts, and personal conversations. This has resulted in virtually no difficulty in collecting co-payments.

JOHN K. HAYCRAFT, Chief
Medical Administration Service

QUESTIONS SUBMITTED BY HONORABLE G. V. MONTGOMERY
TO DEPARTMENT OF VETERANS AFFAIRS MEDICAL CENTER
LITTLE ROCK, ARKANSAS
AT THE SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
JUNE 20, 1990
THIRD PARTY REIMBURSEMENT

1. HAVE YOU BEEN ABLE TO COMMIT THE NECESSARY RESOURCES AND PERSONNEL FOR THIRD PARTY BILLING AND COLLECTION? IF NOT, WHY?

Yes.

2. WITH THE FOCUS ON INCREASING COLLECTIONS, MORE EFFORT WILL BE PLACED ON IDENTIFYING THOSE VETERANS WITH INSURANCE. MIGHT THIS RESULT IN TURNAWAYS OF SOME VETERANS NOT MANDATED CARE WHO DO NOT HAVE PRIVATE INSURANCE?

We feel this would have no effect on treatment provided veterans, whether or not they have insurance.

3. WHAT HAS BEEN YOUR EXPERIENCE IN COLLECTING CO-PAYMENTS? WHAT ARE THE PROBLEMS?

The only problem encountered was that when we began collecting co-payments, some veterans resisted mainly because of lack of knowledge about the program. We thought we had done an excellent job in preparing them, but found instances where we could do better. For instance, we asked to participate in meetings of Veterans Service Organizations, prepared handouts, and assigned personnel to explain the co-payment process to veterans on a one-to-one basis. Any problems related to collecting co-payments have been virtually eliminated.

JOHN B. MAYCRAFT, Chief
Medical Administration Service

Medical Center Martinsburg WV 25401

Department of Veterans Affairs

July 24, 1990

In Reply Refer to: 613/136C1

Honorable G. V. (Sonny) Montgomery
Chairman, Committee on Veterans Affairs
335 Cannon House Office Building
Washington, DC 20515

Dear Mr. Montgomery:

In reference to your letter of July 3, 1990, enclosed are the answers to additional questions for the Subcommittee on Hospitals and Health Care.

I was very honored to be able to testify on behalf of the Department of Veterans Affairs for the Martinsburg facility in regard to Third Party Reimbursement. Through our efforts, we have been able to achieve great success with this program and we are very proud of our accomplishment.

If we can be of any further help, please feel free to contact me at any time.

Sincerely yours,

Norma Jean Brown

NORMA JEAN BROWN, Chief
Insurance/Billing/Fee Services

Enclosures

QUESTIONS SUBMITTED BY HONORABLE JOHN PAUL HAMMERSCHMIDT
TO DEPARTMENT OF VETERANS AFFAIRS MEDICAL CENTER
MARTINSBURG, WEST VIRGINIA
AT THE SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
JUNE 20, 1990
THIRD PARTY REIMBURSEMENT

1. HAVE YOU COMPARED THE COST-EFFECTIVENESS OF CONTRACTING OUT THIS FUNCTION AS OPPOSED TO KEEPING IT IN-HOUSE?

   No, not in definitive terms. Two studies were completed which included this facility among others. We realize the cost effectiveness would diminish if all cases were involved, not just selective cases. Also, the cost effectiveness would be reduced if the facility was still responsible for the identification and collection of data for a third party case.

2. ARE THERE ANY INCENTIVES OR UNIQUE CIRCUMSTANCES CURRENTLY IN PLACE AT YOUR MEDICAL CENTERS THAT MIGHT EXPLAIN WHY YOU ARE EXCELLING IN THIS AREA AT A FAR GREATER RATE THAN OTHER MEDICAL CENTERS?

   In 1987, a group monetary incentive award was given to all personnel involved in Third Party Reimbursement. Since that time, there have been no monetary awards but the facility has received a lot of praise and recognition due to their consistently high rating in the program.

   We were selected by VACO to conduct a pilot study of outpatient billing and given special funding for Fiscal Years 1989 and 1990. With this, we were able to put a good outpatient billing program in place and this has boosted our collections.

   From the onset of the program, we established a good rapport with all insurance companies we dealt with. Communications were direct, pleasant, but firm in both obtaining precertification, if required, and in collection efforts. Contacts were from the standpoint that our bills are valid, money is due us, and we will pursue collection. Our persistence in this area has paid off.

   Most importantly, effective communications and good working relationships were established between Medical Administration Service, Fiscal Service and Utilization Review.

3. DO YOU HAVE AN ESTIMATE ON HOW MUCH OF AN INCREASE IN COLLECTIONS YOUR FACILITY WOULD ACHIEVE IF YOU COULD SEEK REIMBURSEMENT FOR TREATMENT OF NON-SERVICE CONNECTED CONDITIONS OF SERVICE CONNECTED VETERANS?

   During Fiscal Year 1989, we had 1,225 inpatient episodes of 0-50% service-connected and 560 episodes of 50-100%. During this same time frame, we had 37,015 outpatient visits of 0-50% and 13,855 visits of 50-100%. Based on the number of nonservice-connected veterans who have insurance, it is estimated that 17-18% of service-connected veterans will have insurance.

   The average bill was $2,153 (including inpatient and outpatient).

   TOTAL 52,655 X 17% = 8,951 X $2,153 = $19,272,257 - if 50% were treated for nonservice-connected conditions, additional collections would be $9,636,129.

   If only the less than 50% was billed:

   38,240 X 17% = 6,500 X $2,153 = $13,996,222 - if 50% were treated for nonservice-connected conditions, additional collections would be $6,998,111.

4. DOES YOUR FACILITY EXPERIENCE DIFFICULTIES IN COLLECTING CO-PAYMENTS FROM VETERANS? IF SO, WHAT ARE THE DIFFICULTIES?

   Our collections in this program have been basically good. When the program was put in place in July, 1986, an effort was made to educate the veterans and the Veterans Service Organizations. We have met with very little resistance.

QUESTIONS SUBMITTED BY HONORABLE G.V. (SONNY) MONTGOMERY
TO DEPARTMENT OF VETERANS AFFAIRS MEDICAL CENTER
MARTINSBURG, WEST VIRGINIA
AT THE SUBCOMMITTEE ON HOSPITALS AND HEALTH CARE
JUNE 20, 1990
THIRD PARTY REIMBURSEMENT

1. HAVE YOU BEEN ABLE TO COMMIT THE NECESSARY RESOURCES AND PERSONNEL FOR THIRD PARTY BILLING AND COLLECTION? IF NOT, WHY?

   Yes. This has been possible due to the fact that we have received special funding from VACO to do a pilot study on outpatient billing for the past two fiscal years. If we do not receive extra funding for FY91, we will be unable to accomplish a full scale billing and collection activity.

2. WITH THE FOCUS ON INCREASING COLLECTIONS, MORE EFFORT WILL BE PLACED ON IDENTIFYING THOSE VETERANS WITH INSURANCE. MIGHT THIS RESULT IN TURNAWAYS OF SOME VETERANS NOT MANDATED CARE WHO DO NOT HAVE PRIVATE INSURANCE?

   This would have no effect on treatment provided veterans. Eligible veterans will be treated regardless of whether or not they have insurance.

3. WHAT HAS BEEN YOUR EXPERIENCE IN COLLECTING CO-PAYMENTS? WHAT ARE THE PROBLEMS?

   When this program first began, we apprised Veterans Services Organizations about the program so that if, and when, they had complaints from the veterans they would understand the co-payment process. We have had very little resistance from the veterans. In this demographic area, we tend to think the veterans are, as a whole, basically honest and conscientious in paying their bills.

Medical Center

10701 East Boulevard
Cleveland OH 44106

Veterans Administration

July 24, 1990

In Reply Refer To: 541-04(B)

Honorable G. V. (Sonny) Montgomery, Chairman
U.S. House of Representatives
Committee on Veterans Affairs
335 Cannon House Office Building
Washington, DC 20515

SUBJ: Response to Questions by Department of Veterans Affairs Field Panel

Enclosed please find Cleveland's response to the questions submitted by members of the Department of Veterans Affairs Field Panel, Honorable G.V. (Sonny) Montgomery and Honorable John Paul Hammerschmidt.

Adrienne Frey-Jones

Enclosures:
Questionnaire

Questions submitted by Honorable John Paul Hammerschmidt
to Department of Veterans Affairs Medical Center
Cleveland, Ohio
at the Subcommittee on Hospitals and Health Care
June 20, 1990
Third Party Reimbursement

1) Have you compared the cost-effectiveness of contracting out this function as opposed to keeping it in house?

No we have not. We are at this time still in the process of determining what constitutes the most effective organization (MEO) to accomplish the billing function. If we use the A-76 process as a guide in reviewing contracting out the MEO process is a critical step in determining cost effectiveness.

It should be recognized that much of the cost associated with billing is involved in providing data required by insurers to make a determination on payment. Contracting out the function would not relieve a Medical Center of this requirement.

2) Are there any incentives or unique circumstances currently in place at your Medical Center that might explain why you are excelling in this area at a far greater rate than other Medical Centers?

None that we are aware of.

3) Do you have an estimate on how much of an increase in collections your facility would achieve if you could seek reimbursement for treatment of non-service connected conditions for service connected veterans?

No. All of our efforts have been directed towards implementing the law as it currently is written.

4) Does your facility experience difficulties in collecting copayments from veterans? If so, what are the difficulties?

Yes we do. We have experienced the following problems;

a) Veteran refuses to pay.
b) Inability to locate veteran due to fictitious address.

Questions of Honorable G.V. (Sonny) Montgomery
Questions for Department of Veterans Affairs Field Panel
Department of Veterans Affairs Medical Center
Cleveland, Ohio

1) Have you been able to commit the necessary resources and personnel for third party billing and collection? If not, why?

We have been unable to commit the necessary resources and personnel to third party billing and collections. This has been due to the fact that no additional resources were received for this initiative. Personnel devoted to this activity have had to be at the expense of direct medical care. We estimate a need for a 50% increase in our current staffing levels in this function in order to implement billing for outpatient services.

2) With the focus on increasing collections, more effort will be placed on identifying those veterans with insurance. Might this result in turnaways of some veterans not mandated care who do not have private insurance?

The Cleveland Medical Center does not utilize the fact that a veteran has private insurance as a basis for providing access to medical care.

3) What has been your experience in collecting copayments? What are the problems?

We have experienced the following problems;

a) Veteran refuses to pay.
b) Inability to locate veteran due to fictitious address.

Birch & Davis Associates, Inc.
8905 FAIRVIEW ROAD
SILVER SPRING, MARYLAND 20910
(301) 589-6760
TELEX: 856468 (B&DUD) FAX: (301) 650-0398

July 25, 1990

G.V. (Sonny) Montgomery
Chairman
Committee on Veterans' Affairs
U.S. House of Representatives
335 Cannon House Office Building
Washington, DC 20515

Dear Congressman Montgomery:

Thank you for the opportunity to attend the hearings on June 20. Attached are my answers to the additional written questions from you and Congressman Hammerschmidt. I would be pleased to provide any additional information you would like.

Also, I would welcome an opportunity to explain to you or members of your staff the way in which I believe the DVA and the private sector can collaborate to their mutual advantage to effectively and efficiently meet the DVA's third-party billing and collections needs.

Sincerely,

BIRCH & DAVIS ASSOCIATES, INC.

Clint G. Gardner
Principal

QUESTIONS SUBMITTED BY HONORABLE JOHN PAUL HAMMERSCHMIDT

1. I have heard criticism with regard to contracting out the billing and collections program which alleges that contractors may not approach the veteran patient with as much sensitivity as a Department employee. There is concern that the contractor would be too aggressive in collecting. Could you respond to this from your experience?

In the two years I have been studying third-party billing and collections in the DVA, I, too, have heard this criticism (and variations of it) as a reason why the private sector should not be engaged to assist with billing and collections.

I believe that this concern will not withstand even superficial analysis or scrutiny. There seem to be two underlying hypotheses upon which this criticism is based. These hypotheses are, I believe, both quite erroneous.

- **Contractor employees possess a lesser amount of respect for or are less capable of understanding Veterans, their medical needs, or the DVA's health care mission than DVA employees.**

  As a rationale for not engaging contractors, this is, of course, absurd. Talent, manner, competence, respect, diligence, and simple courtesy are as varied among DVA employees (current and future) as they are among private-sector employees. Employee selection, training, and management are the keys to ensuring that any billing and collections employees (DVA or contractor) interact with Veterans in a professional, respectful, and productive fashion. These tasks are identical in either a DVA or private-sector setting.

- **Contractors will operate in pursuit of medical collections revenue to the exclusion of, or in direct conflict with, DVA health care mission objectives.**

  All contractor activities to collect medical accounts will be defined by, limited by, and evaluated against the terms of the contract between the DVA and the contractor. Furthermore, contractor actions will be subject to continual review by VAMC Fiscal and MAS personnel and, ultimately, the VAMC Director. Consequently, contractor collection efforts on behalf of the VAMC will be only as aggressive or as passive as the DVA and the VAMC wish.

  The philosophies directing medical accounts collections operations at different VAMCs vary widely, from quite aggressive to quite passive. Within the boundaries set by the Central Office, VAMCs would retain this flexibility if billing and collections were contracted.

In March 1990, B&D submitted an unsolicited proposal to begin contracted billing and collections at a DVA hospital. The proposal was titled **Proposal for a Public/Private Partnership to Maximize Billing and Collections.** A copy of this proposal was given to the DVA's Medical Care Cost Recovery (MCCR) Task Force. A short excerpt from the operational terms we proposed to the VAMC and to the MCCR follows:

> At no time, however, shall B&D implement any collections procedures for category C copayment bills until such procedures have received approval from the DVA. For category C copayment bills, B&D will proactively solicit and respect DVA wishes with regard to collection techniques, methods of communication, specific text or language, and period for repetition of claim request.

An overview of the operational plan for such a public/private partnership is attached as Appendix A.

2. What advantages could be realized by the department by contracting out the billing and collections services? Do you believe contracting the services would be more cost-effective for the Department?

I believe that collaboration between the DVA and the private-sector organization should not be viewed simply as "contracting out," but as an opportunity for a public/private partnership that can benefit the government, Veterans, and the private-sector firm(s) involved. Under the terms of the public/private partnership we envision, a contractor would be reimbursed only from the proceeds of collections generated by the contractor's activities. The contractor would assume all risk for the success of operations. This no-cost, no-risk approach has many significant advantages for the DVA:

- No appropriated funds would be expended by the DVA in support of billing and collections operations.

- No additional staff would be required by the DVA in support of billing and collections operations.
- No additional workload would be assumed by the DVA in support of billing and collections operations.
- No additional equipment or systems would be required by the DVA in support of billing and collections operations.
- Strong, powerful, and inherent financial incentives will ensure success in enhancing billing and collections operations.
- The DVA will assume no risk, should expected billing and collections fail to materialize.

The DVA, then, will not incur any costs or risks associated with billing or collections activities under this plan. Further, all contractor billing and collections activities performed on behalf of the DVA will be self-managed by powerful financial and performance incentives.

In addition, a public/private partnership (unlike any other plans of which we are aware) will have absolutely no negative impact on a VAMC's ability to provide timely and quality care, and will have no negative impact whatsoever on beneficiaries.

In short, through a public/private partnership the DVA can access the resources, skills, technology, and management of the existing private-sector bill-processing and collection industry quickly and for no cost.

This option seems particularly attractive when compared to the DVA's other major operational option: in-house performance. In-house performance of billing and collections by DVA staff using DVA-owned equipment and systems will require:

- Lengthy start-up times, during which considerable billing and collections opportunities will be lost
- Extensive upgrade and reprogramming to the DVA's Decentralized Hospital Computer Program (DHCP) systems
- Acquisition of additional CPU capacity at many VAMCs
- A massive training program for some 800 FTEs
- Production and distribution of complex and lengthy policy and procedure manuals
- Diversion of 500 FTEs from clinical to administrative tasks (as currently outlined in the President's 1991 budget)

Clearly, a public/private partnership has significant operational and cost advantages over either in-house performance or performance under traditional contracting methods (i.e., cost-plus-fixed-fee or fixed-price).

Two factors substantiate this assertion:

- Opportunity Lost--Implementation of an in-house DVA billing and collections program aimed at maximizing collections will be hampered by systems design, staff acquisition, and myriad political and managerial issues. The DVA currently has the opportunity to bill as much as $796 million per year, yet collected only $100 million last fiscal year. The DVA can ill afford delay in beginning a comprehensive collections program, when each passing work day represents a $3.06-million billing opportunity.
- Bill Processing Costs--GAO reported that it costs the DVA approximately $27 to prepare and process one third-party bill. Due largely to economies of scale and sophisticated automation, the private sector can prepare and process third-party bills for 15 to 40 percent as much.

3. In your opinion, how much would it cost the Department to institute a cost effective and efficient billing collections program? Do you believe the additional staff and resources requested by the department are sufficient to do the job at all 169 DVA Medical Centers?

The President's FY 1991 budget indicates that $25 million are to be devoted "to reflect the billing and collections activities in the Department of Veterans Affairs third-party medical recoveries program."

The $25 million initiative includes $19.2 million to support 800 FTEs and $1.25 million for (unspecified) equipment. This equates to approximately 4.65 FTEs and $72,600 in new equipment for each of the DVA's 172 VAMCs. Overall, the initiative will place $145,300 at the disposal of the average VAMC. These resources are insufficient to achieve a level of billing and collections performance that even approaches maximum.

Further, 500 of the 800 FTEs and an unknown portion of the funds for other items are to be taken from current VAMC staffing complements and medical resources. The budget states:

> In 1991 only...these activities will be funded in part by a transfer of funds and staff from the medical care account. This transfer simply reflects a redirection of resources devoted to third party billing and collections from the medical care appropriation request to the new third party account.

After FY 1991, the initiative is hoped to be self-sustaining.

If we assume that five-eighths (or $15.6 million) of overall initiative resources are to be culled from the existing VAMC medical care account, only 1.74 additional FTEs and $45,300 of new equipment will be devoted to each VAMC. This level of commitment is unlikely to produce a self-sustaining initiative within one fiscal year.

Clearly, the resources required to maximize billing and collections are not forthcoming from within the system--or through normal appropriations channels.

It is largely for this reason that I believe collaboration between the public and private sectors via a public/private partnership is the clearest choice for virtually immediate realization of dollars owed the DVA.

QUESTIONS OF HONORABLE G.V. (SONNY) MONTGOMERY

1. Are copayment collections more costly than third party collections? If so, why?

I have not directly studied the in-house costs associated with either third-party or copayment collections in the DVA.

Intuitively, however, I believe (assuming efficient operations) that copayment bills are marginally less costly to produce on a per bill basis than third-party bills. I base this statement on the following:

- A somewhat lesser amount of demographic data collection is required for preparation of a copayment bill than is required for a third-party bill.
- Copayment bills do not require precertification, concurrent review, or other utilization- or access-related administrative requirements.
- Copayment bills do not require discharge or diagnosis coding.

In total, then, copayment bills require less data collection and preparation--and therefore cost less to prepare.

I also believe that copayment bills are (again, assuming efficient operations) significantly more costly than third-party bills if dollars collected is used for the basis of comparison. I base this statement on the following:

- Third-party bills require only marginally more resources to create than copayment bills, but usually they are for considerably larger dollar amounts. For example, a third-party bill costing only 10 to 15 percent more to prepare than a copayment bill may yield collections 10- or 20-fold the maximum amount of a copayment bill.
- Historically, VAMCs have attained better cash-to-revenue rates (collections percent) for third-party bills than they have for copayment bills. I believe, given current conditions in the DVA, that if equal amounts of resources were devoted to preparation of third-party and copayment bills, the third-party bills would yield a much larger dollar amount of collections.

In total, then, copayment bills require marginally fewer resources to prepare and yield considerably fewer dollars.

Finally, to answer your question as directly as I can:

- Copayment bills are probably marginally less costly bill-for-bill--if bill preparation costs are used as the basis for comparison.
- Copayment bills may well be significantly more costly bill-for-bill--if dollars ultimately collected is used as the basis for comparison.

VETERANS OF FOREIGN WARS OF THE UNITED STATES

OFFICE OF THE DIRECTOR

October 5, 1990

The Honorable G. V. "Sonny" Montgomery
Chairman
Committee on Veterans' Affairs
United States House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

Enclosed is the VFW's responses to questions that time did not allow to be asked at the June 20, 1990, hearing in regards to "third party reimbursement".

With best wishes and kind regards,

Sincerely,

JAMES MAGILL, Director
National Legislative Service

slw
Enclosure

QUESTIONS AND RESPONSES

Hearing of
June 20, 1990
Third Party Reimbursement

Question submitted by John Paul Hammerschmidt

QUESTION #1: You state that the VFW supports a portion of the revenues collected being returned to the VA. Should the funds be deposited into the Medical Care Account or to the Department in general?

RESPONSE #1: Medical Care Account.

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Questions submitted by G. V. "Sonny" Montgomery

QUESTION #1: The private sector witness quoted a GAO report that 89 percent of veterans did not object to VA's recovering a portion of the cost of their non-service-connected care from their insurance companies. What is your response to that finding?

RESPONSE #1: While not being knowelegable of the total sample taken, we can state this does not reflect the feeling expressed by our membership at our National Conventions during debate on pending resolutions.

QUESTION #2: The VA testified that recovering the costs of non-service-connected care from service-connected veterans is consistent with current law regarding Wrokers Compensation laws, crime victims programs and so forth. What is your view on this topic?

RESPONSE #2: Congress, reflecting the will of the people, enacted specific statutes that ensure care for non-service-connected conditions for veterans who are rated 50 percent or more for a service-connected disability. We would object to changing current law that would remove this unencumbered entitlement.

QUESTION #3: In your opinion, should the VA's medical care account absorb the majority of the upfront cost of the Department's third party recovery proposal?

RESPONSE #3: No. There should be an up-front appropriation for this purpose.

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The American Legion

For God and Country

★ WASHINGTON OFFICE ★ 1608 "K" STREET, N.W. ★ WASHINGTON, D.C. 20006 ★
(202) 861-2700 ★

August 2, 1990

The Honorable G.V. (Sonny) Montgomery
Chairman, Committee on Veterans' Affairs
U.S. House of Representatives
Washington, D.C. 20515

Dear Mr. Chairman:

This is in response to your request that we provide follow-up comment on questions submitted relative to the Subcommittee on Hospitals and Health Care hearing of June 20, 1990.

Question 1 - The private sector witness quoted a GAO report that 89 percent of veterans did not object to VA's recovering a portion of the cost of their nonservice-connected care from their insurance companies. What is your response to that finding?

Answer - We question whether 89 percent of the veteran population would agree with the recovery of the cost of their VA health care from their insurance companies. However, aside from that, The American Legion has consistently opposed the implementation of third party reimbursement, even before the legislation which eventually became enacted as PL 99-272 was considered. The delegates to the National Convention of the Legion have resoundingly adopted resolutions to oppose its enactment, and since it has been the law of the land, we have been mandated by our membership to express continued opposition. The philosophy of The American Legion is that third party reimbursement and the means test - have in fact effected essential changes in the nature of the VA health care program by making it a cost-sharing program rather than a benefit program as intended by the American people, acting in their concern for the men and women who have defended the national interest in the Armed Forces of the United States.

Question 2 - The VA testified that recovering the costs of nonservice-connected care from service-connected veterans is consistent with current law regarding Workers Compensation, crime victim programs and so forth. What is your view on this topic?

Answer - VA's views concerning the consistency of its programs with other federal programs is not a matter for consideration by The American

Legion. Veterans programs are special programs designed for a special class of citizenry -- men and women who have given of themselves in defense of our Nation. To compare their programs with certain others simply to support a particular point of view is a disservice to them.

Question 3 - In your opinion, should the VA's medical care account absorb the majority of the upfront cost of the Department's third party recovery proposal?

Answer - The VA's medical care account faces enough problems without adding to their burden by forcing it to absorb the additional costs of third party recovery. The American Legion opposes any effort to place these added expenses on VA health care.

Mr. Chairman, as always The American Legion appreciates your interest in its views on these important matters.

Sincerely,

JOHN F. SOMMER, JR.
Director
National Veterans Affairs and
Rehabilitation Commission

PARALYZED VETERANS
OF AMERICA
Chartered by the Congress
of the United States

July 30, 1990

The Honorable G.V. (Sonny) Montgomery
Chairman, House Committee on Veterans' Affairs
335 Cannon House Office Building
Washington, D. C. 20515

Dear Mr. Chairman:

Enclosed please find the answers to additional questions in reference to the Subcommittee on Hospitals and Health Care hearing of June 20, 1990.

Sincerely yours,

Frank R. DeGeorge

Frank R. DeGeorge
Associate Legislative Director

Enclosure

801 Eighteenth Street, N.W., Washington, D.C. 20006 (202) USA-1300 Fax (202) 785-4452

Questions of Hon. G.V. (Sonny) Montgomery

1. The private sector witness quoted a GAO report that 89 percent of veterans did not object to VA's recovering a portion of the cost of their nonservice-connected care from their insurance companies. What is your response to that finding?

The above statement, quoted by the public sector witness, has far reaching implications concerning the future of the Department of Veterans Affairs (DVA) health care. In the context in which this statistic was provided, basing legislation upon such numbers would not be appropriate. This particular statistic was obtained from a 1985 General Accounting Office (GAO) report. GAO performed this study prior to the enactment of Public Law 99-272, authorizing VA to recover reasonable costs of care for the treatment of insured veterans who do not have service-connected disabilities.

Since the enactment of this law, many factors in the health care arena have changed, both for veterans and non-veterans. Over the past several years, the Nation has struggled with a budget deficit, advances in medical technology allowing Americans to live longer, and rapidly rising costs of medical care. For veterans, these changes have resulted in restricting VA medical care to only the most needy, while the quality of VA care has declined. Based on the changes which have occurred in veterans health care since 1985, it is questionable that the statistics quoted by the public sector witness continue to apply today.

The private sector witness also states in his testimony, "There is, then a significant difference between the amounts of premium payments made by veterans and their civilian employers to private insurance companies, and the amounts of claims paid by insurance companies to cover medical care for these same veterans. In effect, the premium made by veterans and their employers provide a subsidy to non-veteran insurance beneficiaries." Clearly, if this subsidy disappears as a result of VA collecting from third-party carriers for the cost of medical care provided to service-connected veterans, premiums for all beneficiaries--veterans and non-veterans--will rise. PVA questions the possibility that 89 percent of veterans would support increases in their health insurance premiums under these circumstances.

PVA, therefore, continues to advocate that any proposal to expand receipts from third-party payers for the cost of medical care to service-connected veterans for nonservice-connected disabilities is clearly not in the best interest of the Department, the veteran population, or the public.

2. VA testified that recovering the costs of nonservice-connected care from service-connected veterans is consistent with current law regarding workers compensation law, crime victims programs and so forth. What is your view on this topic?

The Department states that this proposal is necessary in order to make their Third-Party Medical Care Cost Recovery Program more consistent. Attempting to make this cost recovery program more consistent between service-connected and nonservice-connected veterans is not an appropriate reason to change existing law. Title 38, USC, mandates that service-connected disabled veterans, rated 50 percent or more, are entitled to medical care and services provided by the Department regardless of insurance status. This law clearly demonstrates that veterans with service-connected disabilities have the highest degree of priority within the DVA system. PVA continues to regard the collection of third-party receipts for the cost of medical treatment currently provided under existing law, as undermining historic legislative intent established in Title 38, USC, as well as a serious breach of commitment to our Nation's veterans.

3. In your opinion, should the VA's medical care account absorb the majority of the up-front cost of the Department's third party recovery proposal?

In VA's effort to enhance the current Medical Care Cost Recovery Program, the Adminstration is seeking authorization to utilize DVA staff (500 FTEE) and

medical care funds ($18,600,000) during Fiscal Year 1991. Regardless of the amount of funds anticipated to be recovered, this transfer of FTEE and funds in Fiscal Year 1991 will create a serious drain on an already over-burdened system. Taking into consideration the present state of VA's medical care account and the funding shortfalls experienced by the VA, PVA does not support the transfer of funds and FTEE from the medical care account to the Medical Care Cost Recovery Program.

Questions submitted by the Honorable John Paul Hammerschmidt

1. Your testimony warns the Department to "avoid aggressive collection efforts" which might inhibit the veteran from seeking health care. Do you have any suggestions for the Department as to how it can let veterans know that they are serious about collections?

As we stated in our testimony, PVA supports enhanced efforts to collect co-payments from "Category C" veterans. We do, however, caution the Department to avoid aggressive collection efforts which could serve to inhibit veterans from seeking health care. Our apprehension is based on GAO statistics which indicate that out of 159 medical centers, veterans at 71 centers (who neglected to pay their co-payments) frequently stated that they could not afford to pay the amount due. Should the Department pursue aggressive collection techniques, DVA may possibly eradicate the last opportunity for these veterans to obtain health care.

In an effort to let veterans know that the Department is serious about collection of co-payments, it need only follow the recommendation of the GAO in the March 1990 report, VA HEALTH CARE: Medical Centers Need to Improve Collection of Veterans' Co-Payments. GAO recommends that collection efforts can be greatly improved if the Department attempted to collect co-payments from veterans or make payment arrangements while veterans are still at medical centers. Implementing such a procedure, (also recommended by the Healthcare Financial Management Association) would indicate the Departments commitment to collection efforts. However, PVA once again advises the Department that steps should be taken to protect "Category C" veterans who indicate an inability to meet the required co-payment.

DISABLED AMERICAN VETERANS
Response to Questions
from the
Honorable G. V. (Sonny) Montgomery

1. The private sector witness quoted a GAO Report that 89 percent of veterans did not object to VA's recovering a portion of the costs of their nonservice-connected care from their insurance companies. What is your response to that finding?

   Answer: Our understanding is the information referred to was contained in a 1985 GAO Report, prior to the enactment of Public Law 99-272, authorizing VA to recover reasonable costs of care for the treatment of veterans without service-connected disabilities. It appears, therefore, such a quote, though accurate in the context in which it was made, is not necessarily reflective of veterans' opinions today. Although the DAV has not surveyed our membership regarding this particular issue, it is our belief that should we do so, the members' views would not be similar to that previously quoted by GAO. The DAV continues to oppose extending VA's authority to recover the cost of care provided to an insured service-connected disabled veteran when treated for a nonservice-connected disability. We believe to do so would be bad for veterans, bad for the VA, and a breach of the American people's commitment to service-connected disabled veterans.

2. The VA testified that recovering the costs of nonservice-connected care from service-connected veterans is consistent with current law regarding Workers Compensation laws, crime victims programs and so forth. What is your view on this topic?

   Answer: Clearly, the Workers Compensation program, as well as the various crime victims programs fulfill a defined need for certain cohorts of individuals and should continue to do so. However, there is no logical basis for attempting to draw a comparison between service-connected disabled veterans and individuals covered by other various federal or state statutes. Individuals disabled as a result of employment, thus entitled to Workers Compensation have, we believe, little in common with a 19 year old boy who, in the defense of his country, loses both legs during armed combat with an enemy of the United States. Philosophically, there is no similarity, in our view, between individuals disabled in conjunction with civilian employment and a combat disabled veteran wounded in the line of duty.

3. In your opinion, should the VA's medical care account absorb the majority of the upfront cost of the Department's third party recovery proposal?

   Answer: Part of VA's legislative initiative is the proposal to transfer, from the medical care account, $18.6 million to support 500 full-time employees to be devoted exclusively to third-party recovery efforts. Medical care funds should not be used for this purpose. Over the years, especially the past three, when one hears about VA medical care it is almost always in the context of inadequate services being provided to entitled disabled veterans as a result of inadequate funding. To transfer funds from an already underfunded account in order to fund an administrative program with absolutely no direct benefit to disabled veterans is incomprehensible. The DAV opposes such an effort.

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